CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

EP 23907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type (cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E. Farber M.D. Title: Commissioner of Health 3/20/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	☐	☒	☐

REMARKS:

C P Force 3/20/63
Records Management Officer Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

G75211 BALTIMORE CITY HEALTH DEPARTMENT G75211

BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) JOHN [illegible]NIEL MC WILLIAMS

2. DATE OF DEATH June 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: Yrs. 7 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Ga. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Simons

D. STREET ADDRESS (If rural, give location) Box 73

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	12/14/16	32				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	US Coast Guard	NC	USA

13. FATHER'S NAME: Charles C. Mc Williams

14. MOTHER'S MAIDEN NAME: Hilda Toldson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 2	267-36-7351	Records- US Marine Hospital, Balto. Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lymphosarcoma with generalized metastasis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Unknown

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar. 10, 1949, *to* June 8, 1949, *that I last saw the deceased alive on* June 8, 1949 *and that death occurred at* 7:50 PM, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M. D.	US Marine Hospital, Balto. Md.	6/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
Burial	June 13. 1949		Wahunta Georgia

DATE RECEIVED BY LOCAL REGISTRAR: JUN 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

FUNERAL DIRECTOR: Pott & B. M. Weaver

ADDRESS: Brent & Stuckert Sts

VS 150

55E

G75212

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75212

1. NAME OF DECEASED (Type or Print): William Eckert

2. DATE OF DEATH: June 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 3503 Elm Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. — B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3503 Elm Ave. 13-06

5. SEX: Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 14, 18 — 9. AGE (In years last birthday): 90 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Fireman — 10B. KIND OF BUSINESS OR INDUSTRY: Baltimore, City

11. BIRTHPLACE (State or foreign country): Md. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Amanda Eckert — ADDRESS: 3503 Elm Ave

MEDICAL CERTIFICATION

(Please write plainly, and fill in all blanks. Physician please write in ink. Correct age is especially important.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute cardiac dilatation and pneumonia, Edema — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

DUE TO (B) Senility, General Arterial Sclerosis. — 15 yrs.

DUE TO (C) Chronic Bronchitis, Prostatism 10 years duration — 10 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Above

19A. DATE OF OPERATION: None — 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1939 *to* June, 1949 *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* 2:30 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE: Brent Q. Tilden M. D. — 23B. ADDRESS: 3615 Fare Rd — 23C. DATE SIGNED: June 9, 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: June 11, 49 — 24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet — 24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 10 1949 — REGISTRAR

25. FUNERAL DIRECTOR: Frank H. Leitz — ADDRESS: 814 N. 36th St.

137a

G75213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75213

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Rudolph Muller

2. DATE OF DEATH June 9th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 160 N. Bradford St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

C. Length of stay in Baltimore: Life 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 160 N. Bradford St 8.42

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Feb 3rd 1871 | 9. AGE (In years last birthday) 77 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY Retired | 11. BIRTHPLACE (State or foreign country) Switzerland | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Kaspar Muller | 14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Louise Muller | ADDRESS 160 N. Bradford

MEDICAL CERTIFICATION

(Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.)

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Insufficiency
DUE TO
(B) Arteriosclerosis (Generalized)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1949 *to* June 9, 1949, *that I last saw the deceased alive on* April 1949, *and that death occurred at* 1h m., *from the causes and on the date stated above.*

23A. SIGNATURE Arnold Lamm M. D. | 23B. ADDRESS 1619 North Dr | 23C. DATE SIGNED 6/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE June 13th 1949 | 24C. NAME OF CEMETERY OR CREMATORY Jewish Museum | 24D. LOCATION (City, town, or county) (State) Belair Road

DATE RECEIVED BY LOCAL REGISTRAR JUN 10 1949 | REGISTRAR'S SIGNATURE Huntington Williams M.D. | 25. FUNERAL DIRECTOR Leo Gabrook | ADDRESS 1705 N. Patterson Park Ave

VS 150

97

LORENZ ✓

G75214 — BALTIMORE CITY HEALTH DEPARTMENT — 608 — G75214

BIRTH NO. — **CERTIFICATE OF DEATH** — Registered No.

1. NAME OF DECEASED (Type or Print): Fred Lorenz (Lorentz)
2. DATE OF DEATH: 6/8/49
3. PLACE OF DEATH: A. Baltimore City, Maryland — B. 2 N. Carey St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Home
C. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE: Md — B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto — D. STREET ADDRESS (If rural, give location): 3214 Lyndale Ave 27-01
5. SEX: Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) — 8. DATE OF BIRTH: Aug 5th 1880 — 9. AGE (In years last birthday): 68 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Moving Pictures — 10B. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): Md — 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME — 14. MOTHER'S MAIDEN NAME: Elizabeth Schmidt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: 212-28-4183 — 17. INFORMANT — ADDRESS: Mrs. Elizabeth French 3214 Lyndale Ave

MEDICAL CERTIFICATION — Please write the cause of death clearly and legibly. Physician please write important. Please write special.

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc., it means the disease, injury or complication which caused death.)
(A) Extravasation of urine into Perineum & Scrotum — DUE TO — ?
(B) Stricture of urethra — DUE TO — ?
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: ? — 19B. MAJOR FINDINGS OF OPERATION: ? — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 3, 1949, to June 8, 1949, *that I last saw the deceased alive on* June 3, 1949, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jno. R. Johnson M.D. — 23B. ADDRESS: 403 Medical Arts Bldg — 23C. DATE SIGNED: 6/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: June 11th 1949 — 24C. NAME OF CEMETERY OR CREMATORY: Baltahem — 24D. LOCATION (City, town, or county) (State): E North Ave Ext

DATE RECEIVED BY LOCAL REGISTRAR: JUN 10 1949 — REGISTRAR'S SIGNATURE: Cuthbert Williams, M.D. — 25. FUNERAL DIRECTOR — ADDRESS: Leo J. Leach 1703 N. Patterson Park Ave

VS 150

136a

G75215

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 43

G75215

Registered No.

1. NAME OF DECEASED (Type or Print): Ada R. Seyfferth

2. DATE OF DEATH: 6-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 118 N. Potomac St.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 118 N. Potomac St 6-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Married	Jan 15 1881	68		

10A. USUAL OCCUPATION (Kind of work done during most of working life. Do not use retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	

13. FATHER'S NAME: William Burke

14. MOTHER'S MAIDEN NAME: Anna Fleming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war, or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Charles Seyfferth ADDRESS: 118 N. Potomac St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Essential hypertension — ?

DUE TO

(C) Cerebral hemorrhage — 1yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

General debility — -

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22: *I hereby certify that I attended the deceased from* May, 1949, *to* June, 1949, *that I last saw the deceased alive on* June 8, 1949, *and that death occurred at* 7:05 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Lionel Bull M. D.

23B. ADDRESS: 1221 N Eutaw Ave

23C. DATE SIGNED: June 10/1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 6-13-49

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral

24D. LOCATION (City, town, or County) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 10 1949

REGISTRAR'S SIGNATURE: Washington Williams, M.D.

25. FUNERAL DIRECTOR: John A. Moran

ADDRESS: 3009 E Balt. St

VS 150

93D

correct age is especial important. Physician please write clearly

G75216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75216

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William A. McDonough

2. DATE OF DEATH: June 8 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1068 Ellwood Ave

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 1068 Ellwood Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 1068 Ellwood Ave 1-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	June 6 1871	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baltimore City Harbor Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael McDonough

14. MOTHER'S MAIDEN NAME: Margaret McDonough

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mary E. McDonough — ADDRESS: 1068 Ellwood Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis

DUE TO

(B) Senility.

DUE TO

(C) Acute Heart Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 46 *to* June 8 49, *that I last saw the deceased alive on* June 8 1949, *and that death occurred at* ____ m. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 2966 E Baltimore

23C. DATE SIGNED: 6-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: June 1949

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Belair Road

DATE RECEIVED BY LOCAL REGISTRAR: JUN 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John C. Moran

ADDRESS: 3000 E Baltimore St

VS 150

95c

correct age is especial important. Physician please write

G75217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

31

G75217

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Annie Gunn

2. DATE OF DEATH June 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1209 N. Central Ave

c. Length of stay in Baltimore: 20 yrs. (Yrs. / Mon. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1209 Central Ave 10-01

5. SEX F | 6. COLOR OR RACE C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH May 9 | 9. AGE (In years last birthday) 61 | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Brunswick Ga.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Malone

14. MOTHER'S MAIDEN NAME Lucy Malone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT James Gunn ADDRESS 1209 N. Central Ave

CAUSE OF DEATH

18.

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Arterio Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1/2 Years

DUE TO

(B) Hypertension — 4 Mos.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician please write the cause of death clearly and legibly. Physician please write the cause of death clearly and legibly. Physician

G75218 ✓ ✓ G75218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ralph Rohrback

2. DATE OF DEATH 6-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Washington
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Keedysville
D. STREET ADDRESS (If rural, give location) RFD #1

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH
9. AGE (In years last birthday) 48 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME George Rohrback
14. MOTHER'S MAIDEN NAME Barbara Waters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Mildred Lowekas ADDRESS Same

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.)

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hemmorrhage from — 12 hrs.
DUE TO
(B) ulceration of Metastic Area
DUE TO
(C) Carcinoma of Larynx — 6 months

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION Feb. 1949
19B. MAJOR FINDINGS OF OPERATION Ca of Larynx
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) a.m. p.m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-29-49 19 *to* 6-9 19 49 *that I last saw the deceased alive on* 6-9 19 49 *and that death occurred at* 10:30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE [signature] M.D.
23B. ADDRESS Mercy Hosp
23C. DATE SIGNED 6-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6-12-49
24C. NAME OF CEMETERY OR CREMATORY Church of God Cem.
24D. LOCATION (City, town, or county) (State) Middletown, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 10 1949
REGISTRAR'S SIGNATURE Compton Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Hadkill & Co. Middletown, Md.

47a

BIRTH NO. G75219

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75219

1. NAME OF DECEASED (Type or Print): EVELYN CHLOE BLACKSTEN

2. DATE OF DEATH: June 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5231 Reisterstown Rd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5231 Reisterstown Rd. 27-18

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Mar. 22, 1903
9. AGE (In years last birthday): 46 yrs. (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stenographer
10B. KIND OF BUSINESS OR INDUSTRY: U. S. F. & G. Co.
11. BIRTHPLACE (State or foreign country): Frederick Co., Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: U. Grant Blackst[illegible]
14. MOTHER'S MAIDEN NAME: Bertha Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Leslie E. Burch ADDRESS: 5231 Reisterstown Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Stomach with Metastasis — Interval between onset and death: Operation Feb 11. 1949
DUE TO
(B)
DUE TO
(C) Hypostatic Congestion — June 6/49

ANTECEDENT CAUSES

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION: Feb 11. 1949
19B. MAJOR FINDINGS OF OPERATION: Large Cyst approximately 35 Lbs. Removed in Toto
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1 1949, to June 9 1949, that I last saw the deceased alive on June 9 1949, and that death occurred at 10:25 P m., from the causes and on the date stated above.

23A. SIGNATURE: W. H. Daly M. D.
23B. ADDRESS: 717 Medical Arts Bldg
23C. DATE SIGNED: June 10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/13/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 10 1949
REGISTRAR'S SIGNATURE: Twington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

49a

G75220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75220

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles E. Mc Glannan — Charles E. McGlannon

2. DATE OF DEATH June 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital DOA
C. Length of stay in Baltimore 64 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 16-06 904 Franklintown Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Married	9/27/1884	64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Flour	Baltimore	U.S.A

13. FATHER'S NAME: Joseph Mc Glannan

14. MOTHER'S MAIDEN NAME: Emma ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	None	

17. INFORMANT: Florence C. McGlannan — ADDRESS: 904 Franklintown Rd

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the exact age if especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23. SIGNATURE: William J. Helfrick M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: June 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/13/49	Western	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John T. Stansbury — ADDRESS: 2700 Edmondson Ave

94a

Dr. White

G75221

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

581.0 G75221 Registered No.

1. NAME OF DECEASED (Type or Print) MARGARET V. GEORGE	2. DATE OF DEATH June 9, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland. B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4301 Arabia Avenue	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
c. Length of stay in Baltimore Yrs. Mos. Days	D. STREET ADDRESS (If rural, give location) 4301 Arabia Avenue 27-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white	married	May 29, 1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Calvert Co, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas H. Harrison	Elizabeth Trott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT, ADDRESS
		Malcolm V. George, 4301 Arabia Ave.

MEDICAL CERTIFICATION

please write the cause of death clearly and if ... by. Physician ... please ... important. ... especial ... correct age is ...

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Esophageal Varices with Profuse Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cirrhosis of liver, Chronic, Hypertrophic Type. — 5 mos.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
—	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* June 8, 1949, *to* June 9, 1949, *that I last saw the deceased alive on* June 8, 1949, *and that death occurred at* 5:38 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James E. Lytle M. D.	5214 Harford Rd.	10 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-13-49	Parkwood Cem.	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 10 1949	Thurlington Williams, MD	Leonard J. Ruck, 5305 Harford Road.

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G75222

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75222

1. NAME OF DECEASED (Type or Print) Mary Anna Klingenberg

2. DATE OF DEATH June 9, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

C. Length of stay in Baltimore 51yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28-04
D. STREET ADDRESS (If rural, give location) 4724 Edmondson Ave., Balto.-29 Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Fe.	White	Widow	7-4-83	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life. "Yes" if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Hwfe.		Austria	

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Albert C. Klingenberg, ADDRESS: 4724 Edmondson Ave.

MEDICAL CERTIFICATION

Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral Bronchopneumonia

DUE TO

(B) Cerebral Vascular Accident

DUE TO

(C) Generalized Arteriosclerosis

Diabetes Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/7/ , 1949, *to* 6/9/ , 1949 *that I last saw the deceased alive on* 6/9/ , 1949, *and that death occurred at* 6:10 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm E. Brown, Jr. M. D.

23B. ADDRESS: 1400 N. Caroline Street

23C. DATE SIGNED: 6/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 6/11/49

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.

24D. LOCATION (City, town, or county) (State): 4430 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 10 1949

REGISTRAR'S SIGNATURE: Livingston Williams, M.D.

25. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.

ADDRESS: 2601-3-5 E. Madison Street

VS 150

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G75223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75223

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Cook

2. DATE OF DEATH 6/9/49

3. PLACE OF DEATH: A. Baltimore City, Maryland B. Baltimore Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Doctors Hospital

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-03
D. STREET ADDRESS (If rural, give location) 2229 E Fayette St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White		-1866	83				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Baltimore	

13. FATHER'S NAME Allen Cook

14. MOTHER'S MAIDEN NAME Mary J. Lawder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	—	Mrs Anna Cunningham	2229 E Fayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Heart Failure — Interval between onset and death: 1 doc

DUE TO

(B) Chronic Congestive Heart Disease — 3 yrs

DUE TO

(C) Arteriosclerosis - Hypertension Probable

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 6-9-1949 to 6-9-1949, that I last saw the deceased alive on 6-9-1949 and that death occurred at 3:20 PM from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis Frank M.D.		

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	6/13/49	Loudon Park	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 10 1949	Lexington Williams M.D.	Philip Henry Sons	Orleans St

VS 150

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Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G75224 TRUE ✓ 43 G75224

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Floy EMMA TRUE

2. DATE OF DEATH: 6/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF ~~HOSPITAL OR INSTITUTION~~ (If not in hospital or institution, give street address or location): 2257 Bedley Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2257 Bedley Ave 25-35

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow | 8. DATE OF BIRTH: Aug 29, 1869 | 9. AGE (In years last birthday): 79 | If under 1 Year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Marion Furr
14. MOTHER'S MAIDEN NAME: Mary Jane Hickman, Century W. Va

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mr Howard Bosley ADDRESS: Century W. Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive C.V.D.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Chronic

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 19 49 *to* June 9, 19 49 *that I last saw the deceased alive on* June 9, 19 49 *and that death occurred at* 9 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul Schofield M.D.
23B. ADDRESS: 1201 Annapolis Rd
23C. DATE SIGNED: 6/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/12/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Vernon
24D. LOCATION (City, town, or county) (State): Barbour, W Va

DATE RECEIVED BY LOCAL REGISTRAR: JUN 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John F Kenny Inc
ADDRESS: 714 Wright St.

VS 150

93D

Please write the cause of death clearly and legibly. Physician: please write the correct age in especially important.

BIRTH NO. 675225

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 675225

1. NAME OF DECEASED (Type or Print) CHARLES FOLLEY McKNEW

2. DATE OF DEATH 10 June 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 211 S Bentalou St

c. Length of stay in Baltimore 77 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-05
D. STREET ADDRESS (If rural, give location) 211 S. Bentalou St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Male	White	married	Feb 29 1872	77	3	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
saw cutter	pasture farm	Baltimore	United States

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nathan McKnew. [illegible]	Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		[illegible]	Anna McKnew	211 S. Bentalou

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc., it means the disease, injury or complication which caused death.)
(A) Diabetes — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

ANTECEDENT CAUSES
(B) Nephritis — years.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	none	none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	none

22. *I hereby certify that I attended the deceased from* 9 June, 1949, to 9 June, 1949 *that I last saw the deceased alive on* 9 June, 1949 *and that death occurred at* 4:00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William Goodman, M. D.	1334 Dolphin Spring Rd.	10 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-13-49	New Cathedral	Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JUN 10 1949

REGISTRAR'S SIGNATURE: Torrington Williams, M.D.

25. FUNERAL DIRECTOR: Louis L. Schwab — ADDRESS: 2101 Frederick Avenue

61

Please write the cause of death clearly and legibly. Physician's special attention is especially important. Please write the correct age.

G75226 ✓X 193 G75226

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Paul Gordon Hagenbuch
2. DATE OF DEATH: June 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland (If not in hospital or institution, give street address or location) 4 East
B. FULL NAME OF HOSPITAL OR INSTITUTION: JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 2 Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Pr. George
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Riverdale
D. STREET ADDRESS (If rural, give location): 5007 Oglethorpe St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Child	6-27-47	1	23	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): DC
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Paul B. Hagenbuch
14. MOTHER'S MAIDEN NAME: Minnie Koepper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Metastatic carcinoma
DUE TO (over)
(B)
DUE TO
(C) Intes. obst. partial.

ANTECEDENT CAUSES
II. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-24- 1949 to 6-10-, 1949, *that I last saw the deceased alive on* 6-10-, 1949, *and that death occurred at* 11:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 6/13/49
24C. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN Cem.
24D. LOCATION (City, town, or county) (State): [illegible] Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 11 1949
REGISTRAR'S SIGNATURE: [signature] Williams, M.D.
25. FUNERAL DIRECTOR: W W Chamberlain Co ADDRESS: Washington D.C.

VS 150

57B

G75227 ✓ 40.1 G75227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William M. Hubner

2. DATE OF DEATH 6/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2534 Arunah ave 1-6-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		July 31, 1895	53	10	9

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post-office
10B. KIND OF BUSINESS OR INDUSTRY Parcel post
11. BIRTHPLACE (State or foreign country) md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Hubner
14. MOTHER'S MAIDEN NAME Rita Ramsow
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Circulatory Collapse — 16 hrs.
DUE TO
(B) Peritonitis — 3 wks.
DUE TO
(C) Ruptured Peptic Ulcer — 3 wks.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Evisceration — 5/27/49

19A. DATE OF OPERATION 5/18/49
19B. MAJOR FINDINGS OF OPERATION Ruptured Ulcer; cholelithiasis
20. AUTOPSY? YES ☑ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 27, 1949, *to* June 10, 1949, *that I last saw the deceased alive on* June 10, 1949, *and that death occurred at* 7:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE John [illegible] Stell M. D.
23B. ADDRESS Mercy Hospital
23C. DATE SIGNED 6/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/13/49
24C. NAME OF CEMETERY OR CREMATORY Woodlawn
24D. LOCATION (City, town, or county) (State) Woodlawn Md.
25. FUNERAL DIRECTOR ADDRESS Wm. Cook Inc. 1217 St. Paul St.

DATE RECEIVED BY LOCAL REGISTRAR JUN 11 1949
REGISTRAR'S SIGNATURE [illegible] Williams, M.D.

VS 150

117a

Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G75228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No. G75228

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ida Virginia Gosnell

2. DATE OF DEATH 6/9/49 1 15 a.m.

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.

5a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 441 W. 24th St

b. STREET ADDRESS (If rural, give location) 403 W. 23rd St. 12-07

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	11/1/1867	81	7	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home

10B. KIND OF BUSINESS OR INDUSTRY Self

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Wm Baker

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give War or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT 5500 Park Ave S.E. Washington D.C. Edith Coleman

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — 1 week

DUE TO

(B) Hypertensive Arteriosclerotic Cardio-vascular disease.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/27, 1949 to 6/9, 1949 *that I last saw the deceased alive on* 6/9, 1949 *and that death occurred at* 7 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE A. Harris M.D.

23B. ADDRESS 2902 Huntington Ave.

23C. DATE SIGNED 6-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6/11/49

24C. NAME OF CEMETERY OR CREMATORY Balto.

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 11 1949

REGISTRAR'S SIGNATURE Washington Williams M.D.

25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1217 St. Paul St.

VS 150

93D

Please write the cause of death clearly and legibly. Physician please write important. Please age is especially important.

G75229

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 1

G75229

Registered No.

1. NAME OF DECEASED (Type or Print) Rosa Feldman

2. DATE OF DEATH June 10, 1949

3. PLACE OF DEATH A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4613 Park Heights Avenue

c. Length of stay: Mt. Lineus Home, Baltimore — Yrs. 60 years, Mos., Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 2815 Santa Fe Avenue 15-13

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 1870

9. AGE (In years last birthday) 79 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Harry Coppersmidt

14. MOTHER'S MAIDEN NAME Lonia Faga

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Samuel Feldman — ADDRESS 2815 Santa Fe Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) A. Cerebral Arteriosclerosis

DUE TO

(C) General arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) a. m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/6, 1949, to 6/10, 1949 *that I last saw the deceased alive on* 6/9, 1949, *and that death occurred at* 12:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE A. L. Hornstein, M. D.

23B. ADDRESS 204 E. Biddle St

23C. DATE SIGNED 6/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6/12/49.

24C. NAME OF CEMETERY OR CREMATORY Sodova Cong. Cem.

24D. LOCATION (City, town, or county) (State) Herring Run, Bowleys Lane

DATE RECEIVED BY LOCAL REGISTRAR JUN 11 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Sol Levinson & Bros. ADDRESS 1124 W North Ave

VS 150

83a

Physician: Please write the cause of death clearly and legibly. Be correct age is especially important. Please write the

G75230

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

Registered No. G75230

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Samuel Starr

2. DATE OF DEATH 6/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hosp
c. Length of stay in Baltimore: 35 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1520 N Carey St 15-01

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 1884
9. AGE (In years last birthday) 65
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer Business
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Solomon Starr
14. MOTHER'S MAIDEN NAME Goldie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Ida Starr ADDRESS 1520 N Carey St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.
DUE TO
(B) Hypertension & arteriosclerosis — ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C) ? —

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HASCVDE auricular fibrilation — ?

19A. DATE OF OPERATION none
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) No
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from 6/9, 1949, to 6/10, 1949 that I last saw the deceased alive on 6/10, 1949, and that death occurred at 12:45 A m., from the causes and on the date stated above.

23A. SIGNATURE John Paul Young, M.D.
23B. ADDRESS West Balto Gen. Hospital
23C. DATE SIGNED 6/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 12, 1949
24C. NAME OF CEMETERY OR CREMATORY Hebrew Rosedale Cem
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 11 1949
REGISTRAR'S SIGNATURE Clayton Williams, MD
25. FUNERAL DIRECTOR Sol Levinson & Bros
ADDRESS 1126 W North Ave

VS 150

93D

PLEASE WRITE CLEARLY, WITH UNFADING INK. Use only capital letters. Do not abbreviate. Be sure to write the cause of death clearly and correct age is especially important. Physician: please write plainly.

G75231

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75231

1. NAME OF DECEASED (Type or Print) Otto Hahn

2. DATE OF DEATH June 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4135 Falls Road
C. Length of stay in Baltimore: 70 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4135 Falls Road 13-07

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: July 29, 1868
9. AGE (In years last birthday): 80 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Hahn
14. MOTHER'S MAIDEN NAME: Mary —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Otto A. Hahn — ADDRESS: 4135 Falls Road

MEDICAL CERTIFICATION

PLEASE WRITE LEGIBLY. WITH ONE CAUSE ON EACH LINE. Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc., it means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 1948 *to* June 6th 1949 *that I last saw the deceased alive on* June 6th 1949 *and that death occurred at* 1 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: K. Trumpatt M. D.
23B. ADDRESS: 1628 E. N. Avenue
23C. DATE SIGNED: 6/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 13, 1949
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JUN 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home
ADDRESS: 3631 Falls Road

VS 150

94a

675232

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 675232

1. NAME OF DECEASED (Type or Print): MICHAEL JACKETTI

2. DATE OF DEATH: June 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: 7 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1818 N. Charles Street 1-2-05

5. SEX: Male
6. COLOR OR RACE: Wh[illegible]
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 16, 1899
9. AGE (In years last birthday): 50 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): City of Baltimore
10B. KIND OF BUSINESS OR INDUSTRY: Highways Depart.
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Jacketti
14. MOTHER'S MAIDEN NAME: Mary ---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 202-10-4838
17. INFORMANT: Mrs. Mary T. Jacketti ADDRESS: 1818 N. Charles St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 6-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: June 11, 1949
24C. NAME OF CEMETERY OR CREMATORY: Hazleton
24D. LOCATION (City, town, or county) (State): Hazleton, Pennsylvania

DATE RECEIVED BY LOCAL REGISTRAR: JUN 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home
ADDRESS: 3631 Falls Road

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be furnished. Correct age is especially important. Physician: please write the cause of death clearly and fully.

G75233

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75233

1. NAME OF DECEASED (Type or Print): John T. Callis

2. DATE OF DEATH: 6/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pasadena
D. STREET ADDRESS (If rural, give location): Colonial Beach Drive

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 2/25/1895
9. AGE (In years last birthday): 54
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard Callis
14. MOTHER'S MAIDEN NAME: Nora Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 217-03-5549
17. INFORMANT: Mrs Edward Kamm ADDRESS: 932 Hanover St.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in the cause of death clearly and completely. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 16 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/24, 1949 *to* 6/9, 1949 *that I last saw the deceased alive on* 6/9, 1949 *and that death occurred at* 8:35 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: John M. Gibson Jr M. D.
23B. ADDRESS: 1213 Light Street
23C. DATE SIGNED: 6/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/11/49
24C. NAME OF CEMETERY OR CREMATORY: Magothy Church
24D. LOCATION (City, town, or county) (State): Anne Arundell Co Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John F Kenny Inc
ADDRESS: 915 Light St.

VS 150

94a

AB-129378
G75234

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75234

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Garfield Prime

2. DATE OF DEATH 6-2-1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore 31yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 212 N. Colvin St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Widowed	Aug. 22-1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) N.J.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Greenwall Prime

14. MOTHER'S MAIDEN NAME Alice Reeves

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S ADDRESS Baltimore City Hospitals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease with failure

(B) Bronchial Asthma

DUE TO

(C) Chronic Bronchitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-2- , 19 49 to 6-4- , 19 49 *that I last saw the deceased alive on* 6-4- , 19 49 *and that death occurred at* 9.30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE R. S. Dozier M.D.

23B. ADDRESS Baltimore City Hospitals

23C. DATE SIGNED 6-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE June 11-49

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem

24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 7 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Eleazo. Wilson

ADDRESS 1000 Brantley

93D

VS 150

PLEASE WRITE PLAINLY, with unfading ink. Be sure the cause of death clearly and legibly. Physician please write the correct age is especially important.

DRIVER ✓

G75235

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

G75235 Registered No.

1. NAME OF DECEASED (Type or Print): Hattie Mae Brown

2. DATE OF DEATH: 6-11-49

3. PLACE OF DEATH
A. Baltimore City, Maryland 2319 Wash Blvd
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore City B. COUNTY: Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 2319 Wash Blvd
D. STREET ADDRESS (If rural, give location): 25-43

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	[illegible]	Married	Feb. 14. 1890	59	3	21	-	-

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-	Housewife	Howard Co Md	U.S.

13. FATHER'S NAME: John Grace

14. MOTHER'S MAIDEN NAME: Celia Parks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Frank T Brown	

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Erasures or alterations invalidate certificate. Write the cause of death clearly and legibly. Correct age is especially important. Physician: please write the

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio Vascular Disease

DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 16, 1944 *to* Feb 12, 1949 *that I last saw the deceased alive on* June 1, 1949, *and that death occurred at* 350 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Carl P Rostling M. D.	1316 W Lombard St	6/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-17-49	Westview	Edmondson Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 11 1949	Huntington Williams, M.D.	Edward Fowlkes	2319 Wash Blvd Balto Md

VS 150

93D

G75236

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 900 D

G75236

Registered No.

1. NAME OF DECEASED (Type or Print) Mrs. Margaret Mary Seifert — N-8210

2. DATE OF DEATH June 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hosp.

C. Length of stay in Baltimore — Yrs. Life. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 620 N. Lakewood Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Widow	Dec. 1, 1881	67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	-	Baltimore, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm. James Knight	Rachel V. Garrish

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	none	Mr. Earl Seifert	620 N. Lakewood Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Enter the cause of death clearly and correct age is especially important. Physician please write the

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Embolism
DUE TO
(B) Fracture Femur - Left
DUE TO
(C) Accident (fall down stairs)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Obesity - Varicose Veins

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
for: W.G. Herrmann, M.D.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES NO | BY MEDICAL EXAMINER

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give street address)
Accident	Home	620 N. Lakewood Ave.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
June 6 1949 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Fell down stairs

22. *I hereby certify that I attended the deceased from* June 6, 1949 *to* June 10, 1949 *that I last saw the deceased alive on* June 10, 1949 *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr. Schuehler M.D.	Bon Secours Hosp.	6/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/13/49	Mount Carmel Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 11 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC.	BALTIMORE - 13, MARYLAND

VS 150

186a

Chas. T. Menzies

G75237

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO BC-40-04186 CERTIFICATE OF DEATH Registered No. G75237

1. NAME OF DECEASED (Type or Print) Chas. T. Menzies

2. DATE OF DEATH 6/10/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SBGH

c. Length of stay in Baltimore Life Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3015 Pretty Hill Ave 6

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S

8. DATE OF BIRTH 2/25/49 | 9. AGE (In years last birthday) | If Under 1 Year: Months 3 Days 14 | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use if retired) none | 10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Baltimore | 12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME Robert Menzies

14. MOTHER'S MAIDEN NAME Margeiret Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Robert Menzies ADDRESS —

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, shock. It means the disease, injury or complication which caused death.)

(A) Status Thymus Lymphaticus — INTERVAL BETWEEN ONSET AND DEATH ?

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — | 19B. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 6/8 1949 to 6/10 1949 that I last saw the deceased alive on 6/10 1949 and that death occurred at 6 P m., from the causes and on the date stated above.

23A. SIGNATURE [signature] M.D. | 23B. ADDRESS SBGH | 23C. DATE SIGNED 6/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE 6/13/49 | 24C. NAME OF CEMETERY OR CREMATORY Parkwood | 24D. LOCATION (City, town, or county) (State) Taylor Funeral

DATE RECEIVED BY LOCAL REGISTRAR JUN 11 1949 | REGISTRAR'S SIGNATURE [signature] M.D. | 25. FUNERAL DIRECTOR Lassahn Funeral Home | ADDRESS 7401 Belair Rd

VS 150

64

PLEASE WRITE PLAINLY, WITH UNFADING INK. Erasures, alterations or omissions may cause delay in issuance of permit. Write the cause of death clearly and if possible. Correct age is especially important. Physician: please write this certificate.

G75238

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75238

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Mary Larkins

2. DATE OF DEATH: June 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1546 N. Fulton ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1546 N. Fulton ave

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct 6 1884
9. AGE (In years last birthday): 64
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Forrister

14. MOTHER'S MAIDEN NAME: Isellany ann. Tasker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Pearl Walters ADDRESS: 1546 N. Fulton ave

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Please write the cause of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. If cause is especially important. Physician please write.

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Myocardial degeneration — 6 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO. ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 3, 1949 *to* June 9, 1949, *that I last saw the deceased alive on* June 9, 1949, *and that death occurred at* 11:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas Finlayson M. D.
23B. ADDRESS: 1543 Pennsylvania Ave
23C. DATE SIGNED: 6/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-13-49
24C. NAME OF CEMETERY OR CREMATORY: mt auburn cem.
24D. LOCATION (City, town, or county) (State): md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 11 1949
REGISTRAR'S SIGNATURE: Tuntsyton Williams, M.D.

25. FUNERAL DIRECTOR: George S. Nelson ADDRESS: 1303 Pierstman St.

VS 150

93D

G75239

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E974.0 G75239 Registered No.

N:991

1. NAME OF DECEASED (Type or Print) CLINTON BROWN

2. DATE OF DEATH June 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1317 North Carey Street 15:01

5. SEX male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Jan. 7, 1904
9. AGE (In years last birthday) 45 If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Ben Brown
14. MOTHER'S MAIDEN NAME Georgianna Dorrey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Anne Brown ADDRESS 1447 N. Carey St.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Cause of death clearly and legibly. Cost of age is especially important. Physician: please write the cause of death.

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) asphyxiation by hanging.
DUE TO
ANTECEDENT CAUSES
(B)
DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE (ACCIDENT, SUICIDE, HOMICIDE) WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1317 North Carey Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) June 9, 1949 12noon
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Hanged self by belt from bedpost

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED June 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6-12-49
24C. NAME OF CEMETERY OR CREMATORY Westminster mvd
24D. LOCATION (City, town, or county) (State) mvd

DATE RECEIVED BY LOCAL REGISTRAR JUN 11 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS George G. Kelson, 1303 Presstman St.

VS 151

164a

BIRTH NO. G75240

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75240

1. NAME OF DECEASED (Type or Print): Blaine Bixler.

2. DATE OF DEATH: June 11 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSP.

C. Length of stay in Baltimore: 23 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Penn. B. COUNTY: Adams
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Littlestown, Rural, Mt Pleasant Twp.
D. STREET ADDRESS (If rural, give location): Littlestown, PA. R. D. 2

5. SEX: Male.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married.
8. DATE OF BIRTH: Nov. 10. 1888
9. AGE (In years last birthday) | If Under 1 Year: Months 7 Days 7 | If Under 24 Hours: Hours Min.: 60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Probation officer
10B. KIND OF BUSINESS OR INDUSTRY: County Office
11. BIRTHPLACE (State or foreign country): Penn
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Samuel Bixler
14. MOTHER'S MAIDEN NAME: Mary Lipp
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs B. E. Bixler, Littlestown, PA ADDRESS R. D. 2

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct as nearly as possible. Every item must be answered. Physician: please write the cause of death clearly and correct age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tumor left Cerebral hemisphere — INTERVAL BETWEEN ONSET AND DEATH: 6 mo?
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(over)

19A. DATE OF OPERATION: 5-24-49
19B. MAJOR FINDINGS OF OPERATION: Bulging medial aspect left lateral ventricle
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1949 to June 11, 1949 that I last saw the deceased alive on June 11, 1949 and that death occurred at 12:20 m., from the causes and on the date stated above.

23A. SIGNATURE: H. Patterson Black M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: Jun 11 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/14/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cem.
24D. LOCATION (City, town, or county) (State): Littlestown, PA.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: J. W. Little & Son, Littlestown ADDRESS PA
Per Richard A. Little

VS 150

57

G7524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75241

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jacob Greg

2. DATE OF DEATH: 6/11/49

3. PLACE OF DEATH: A. Baltimore City, Md. and 3404 St. Ambrose Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY —

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3404 St Ambrose Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-16

c. Length of stay in Baltimore: 26 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 3404 St Ambrose Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	?	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10B. KIND OF BUSINESS OR INDUSTRY: Auto stores

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME: Abraham

14. MOTHER'S MAIDEN NAME: Hannah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Lena Greg ADDRESS: 3404 St Ambrose

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, and correct age is especially important. Physician: please write the cause of death clearly and fully.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 29, 1949 to June 11, 1949, that I last saw the deceased alive on June 10, 1949, and that death occurred at 12 M., from the causes and on the date stated above.

23A. SIGNATURE: Joseph S. Blum M. D. — 23B. ADDRESS: 1154 Calvert St — 23C. DATE SIGNED: 6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 6-12-49 — 24C. NAME OF CEMETERY OR CREMATORY: Hebrew Young Men — 24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 12 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Jack Lewis Inc — ADDRESS: 2100 Eutaw Pl

VS 150

94a

G75242 ✓ G75242

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): WILHELM HIRSCH

2. DATE OF DEATH: 6-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2816 Woodbrook Ave

C. Length of stay in Baltimore: 10 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-04
D. STREET ADDRESS (If rural, give location): 2816 Woodbrook Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Married		77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Germany	

13. FATHER'S NAME: Henrich

14. MOTHER'S MAIDEN NAME: Betty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Edward Hirsch	2816 Woodbrook

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis (cardiac)

DUE TO

(B) Generalized arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1946 *to* June 11 1949 *that I last saw the deceased alive on* June 5 1949 *and that death occurred at* 5 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
KURT [illegible] M.D. 2301 [illegible] Ave Suite 1111 Baltimore 17 Md.	2301 Charles Plaza	6/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-12-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 12 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Every question answered. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

VS 150

940

G75243

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

G75243

Registered No.

1. NAME OF DECEASED (Type or Print) Joseph Cornish

2. DATE OF DEATH June 6 - 46

3. PLACE OF DEATH: A. Baltimore City, Maryland — 654 W Bare

4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE B. COUNTY 654 W Bare

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 654 W Bare 22 02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Col	married	April 30 94	5-5				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
L	—	Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Daniel Cornish	Sarah Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Edith Cornish	654 W Bare St

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if known. Correct age is especially important. Physician: please write the cause of death clearly and forcibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc., it means the disease, injury or complication which caused death.)

(A) Cerebral apoplexy

DUE TO

ANTECEDENT CAUSES

(B) Paralysis

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/4 *19* 46 *to* 6/6 *19* 46, *that I last saw the deceased alive on* 6/6 *19* 46 *and that death occurred at* 10:25 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	213 N Gilmor St	6/10 - 46

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 12 1949	Mt Zion	Balto County

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 12 1949	[signature]	Sarah L Brown Sons	108 W Montgomery St

830

G75244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75244

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print) Muriel Smith (Clarke) 581.0 | 2. DATE OF DEATH 6-9-44

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland | B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 574 Baker St. 1-4-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	C	DIVORCED	11/[illegible]/1909	39		

10A. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	House	Baltimore. Md	U.S.A

13. FATHER'S NAME Chas C. Smith

14. MOTHER'S MAIDEN NAME Wilhelmenia Queen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	Wm. K. Clarke	530 Sanford Pl.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured esophageal varice — INTERVAL BETWEEN ONSET AND DEATH: 10 hours

DUE TO

(B) Hepatic Cirhosis — 2 Mos

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 6-9- 1944 to 6-9- 1944 that I last saw the deceased alive on 6-9- 1944 and that death occurred at 11:45 m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. Bradley Jr. M. D.	Provident Hosp	6-9-44

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/12/44	Arbutus Mem'l. Pk.	Balto. County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 12 1944	Huntington Williams, M.D.	Charles G. Cooper-612	Carrollton Av.

VS 150

124B

G75245 — X ✓ — Epi. 4 G75245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C.H-57590 — Registered No.

1. NAME OF DECEASED (Type or Print): VERNON E. WILLIAMS — N-803. ✓

2. DATE OF DEATH: June 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 5 Melrose Avenue

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: July 18, 1946
9. AGE (In years last birthday): 2 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Theodore Carroll Williams
14. MOTHER'S MAIDEN NAME: Sarah Williams
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Theodore C. Williams — ADDRESS: 5 Melrose Avenue

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc., but means the disease, injury or complication which caused death.)
(A) Fractured skull.
DUE TO
(B) Intracranial hemorrhage.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Melrose Ave. ½ block west of Ingleside Ave.
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: June 9, 1949 3.30p.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? pedestrian Struck by an automobile

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X] suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: June 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/13/49
24C. NAME OF CEMETERY OR CREMATORY: Western Star
24D. LOCATION (City, town, or county) (State): Catonsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Charles G. Cooper-512 Carrollton Av.

170c ✓

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75246

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75246

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mikael Delbo

2. DATE OF DEATH June 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lillie Bliss Mem Hosp

C. Length of stay in Baltimore: 42 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Catonsville
D. STREET ADDRESS (If rural, give location) 5903 KENWOOD AVE

5. SEX M.

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S.

8. DATE OF BIRTH June 14, 1882

9. AGE (In years last birthday) 67
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) HUNGARY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Delbo

14. MOTHER'S MAIDEN NAME Mary Bonczek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Lillie Bliss Hospital ADDRESS 1200 Valley Pk.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc.) but means the disease, injury or complication which caused death.)

(A) DUE TO: Acute Dilatation of Heart — 1 day

(B) DUE TO: Mitral Stenosis — 5 yrs

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 7- *, 1949, to* June 10 *, 1949, that I last saw the deceased alive on* June 10 *, 1949, and that death occurred at* 11:30 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE E. Gill Hall M. D.

23B. ADDRESS 1631 E. North Ave.

23C. DATE SIGNED June 11-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE JUNE 1949

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer

24D. LOCATION (City, town, or county) (State) 4300 Belair Road MD

DATE RECEIVED BY LOCAL REGISTRAR JUN 12 1949

REGISTRAR'S SIGNATURE [illegible]

25. FUNERAL DIRECTOR Duffel Bros. ADDRESS 7110 Belair Rd.

VS 150

92 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if known, as the correct age is especially important. Physician: please write the cause of death clearly and legibly.

BIRTH NO G75247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75247

1. NAME OF DECEASED (Type or Print): Ignatius Lanocha

2. DATE OF DEATH: June 9 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Dr. Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Dr. Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 27-01
3524 Cardenas Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 3524 Cardenas Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH
9. AGE (In years last birthday): 56 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: C.C.S.Co.

11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Paul Lanocha
14. MOTHER'S MAIDEN NAME: Mary Kudla

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Lillian Lanocha
ADDRESS: 3524 Cardenas Ave

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Bilateral Pneumonia Lobar.

DUE TO

(B) Hypertensive Cardio Vascular Renal

DUE TO

(C) Cardiac Failure

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE? (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/20 1949 to 6/9 1949, that I last saw the deceased alive on 6/9 1949 and that death occurred at 9.04 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Nelson D Jamroski M. D.
23B. ADDRESS: 2911 Eastern Ave
23C. DATE SIGNED: 6/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 13/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUN 12 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: Fred W Ozazenski
ADDRESS: 1930 Eastern Ave

VS 150

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G75248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75248

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Cordell C. Clark

2. DATE OF DEATH June 9th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 608 W. Mulberry St.

C. Length of stay in Baltimore: Yrs. 1 Mos. Unk'n Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 608 W. Mulberry Street

5. SEX Female
6. COLOR OR RACE C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W
8. DATE OF BIRTH July 4th 1911
9. AGE (In years last birthday) 37 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baldwinsville, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Douglass Winston
14. MOTHER'S MAIDEN NAME Isabelle Wallace
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Isabelle Winston ADDRESS Baldwinsville, Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B) Cardiac Failure

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 9th, 1949, to June 9th, 1949, *that I last saw the deceased alive on* June 9th, 1949, *and that death occurred at* 6:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE (Est) Robert L. Knudson M. D.
23B. ADDRESS 600 Washington Ave
23C. DATE SIGNED 6-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6-13-49
24C. NAME OF CEMETERY OR CREMATORY Gordonsville Va
24D. LOCATION (City, town, or county) (State) Va

DATE RECEIVED BY LOCAL REGISTRAR JUN 12 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mrs Katie R Williams
ADDRESS 322 N Schroeder St.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physician please write the cause of death clearly and legibly.

94a

G75249
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 15.4 G75249
Registered No.

1. NAME OF DECEASED (Type or Print): Heyward Hoffman N-803.4
2. DATE OF DEATH: 6-12-49
3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto City Hosp
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 4-04
c. Length of stay in Baltimore: 1 yr. (Yrs. Mos. Days)
6. STREET ADDRESS (If rural, give location): 1818 E. Fairmont Ave
5. SEX: M. | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 5/3/24 | 9. AGE (In years last birthday): 23 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carp
10B. KIND OF BUSINESS OR INDUSTRY: Const.
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Richard Hoffman
14. MOTHER'S MAIDEN NAME: Lucy Reynolds
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 239-30-233
17. INFORMANT: Heath Hoffman — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of Skull
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Fayette St. and East Ave. 6-01
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 11, 1949 9:39 P.M.
21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Auto & motorcycle Collison

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl L. Ringer, M.D. | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED: 12 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal | 24B. DATE: 6/14/49 | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State): Fulton Va

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949 | REGISTRAR'S SIGNATURE: Langston Williams, M.D. | 25. FUNERAL DIRECTOR: James J. Brzezynski | ADDRESS: 1402 E. Baltimore St

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75250

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75250

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Winslow B. Ingham

2. DATE OF DEATH: June 11.1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 220 Ridgewood Road
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 8yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 220 Ridgewood Road

5. SEX	6. COLOR	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
male	white	married	5/19/ 1888	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer	Supt. construction	New Jersey	

13. FATHER'S NAME: George T Ingham

14. MOTHER'S MAIDEN NAME: Ann Thrope

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Margaret Ingham ADDRESS: 220 Ridgewood Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1-2 hrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B) Arteriosclerosis Myocarditis — Gradual
DUE TO (C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1945 to June 11, 1949, that I last saw the deceased alive on June 15, 1949, and that death occurred at 6.30P m., from the causes and on the date stated above.

23A. SIGNATURE: M.M. Brady M.D.
23B. ADDRESS: 140 E Park ave
23C. DATE SIGNED: June 12 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/14/49
24C. NAME OF CEMETERY OR CREMATORY: River View Cemetery
24D. LOCATION (City, town, or county) (State): Trenton New Jersey

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John T Mitchell
ADDRESS: 930 1906 Eutaw Pl.

VS 150

G75251

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75251

1. NAME OF DECEASED (Type or Print): Arthur Kirkorian

2. DATE OF DEATH: 6/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2319 W. North Avenue 15-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Divorced	Nov. 12, 1892	56	7 28	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rug Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Rug Salesman
11. BIRTHPLACE (State or foreign country): Armenia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Kirkorian
14. MOTHER'S MAIDEN NAME: Agnes Bajdasarian
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intestinal Obstruction
DUE TO
(B) Carcinoma of Stomach and Generalized Carcinomatosis.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION: 3/9/49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Stomach + obstruction. Carcinomatosis
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/6/, 1949 *to* 6/10/, 1949, *that I last saw the deceased alive on* 6/10/, 1949, *and that death occurred at* 9 a.m./p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles E. Watt, Jr. M.D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 6/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 12 1949
24C. NAME OF CEMETERY OR CREMATORY: Fork M E
24D. LOCATION (City, town, or county) (State): Fork Md

DATE RECEIVED BY LOCAL REGISTRAR: 6-13-49
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Wm Cook Inc. 1217 St Paul St

VS 150

46B

G75252 JL- 5914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75252

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Cleveland Lewis

2. DATE OF DEATH 5-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 28 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) No Street Address

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Single	March 27, 1903 ?	46 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME Mary Wilkerson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT B. C. H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. Be correct age in especially important.

16. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-16- 1936 *to* May 26 1949 *that I last saw the deceased alive on* May 26 1949 *and that death occurred at* 8.45AM *from the causes and on the date stated above.*

23A. SIGNATURE H. S. Rogers M. D.

23B. ADDRESS 4940 Eastern Ave.

23C. DATE SIGNED 6-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY University Medical School JUN 7 1949

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR JUN 7 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Commissioner of Health

ADDRESS

VS 150

61

G75253

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75253

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

1. NAME OF DECEASED (Type or Print) JOSEPH LECHERT — Lechert

2. DATE OF DEATH June 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 743 South Potomac Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (Last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	1889	60		

10A. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Grocer	Grocery	Poland	U. S. A.

13. FATHER'S NAME: Walenty Lechert

14. MOTHER'S MAIDEN NAME: Agnes Godek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Helen Lechert, Wife — ADDRESS: 743 S. Potomac

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE (Accident, Suicide, Homicide) WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 6/14/49

24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cemetery

24D. LOCATION (City, town, or county) (State): German Hill Road

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Mary Weber — ADDRESS: 401 S. Chester St.

93D

G75254

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75254

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Ruth Eudora Price

2. DATE OF DEATH: June-10-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 2798 The Alameda

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home, 2798 The Alameda

C. Length of stay in Baltimore: 29 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 2798 The Alameda 9-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Jan-3-1897	52-5-11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Harney, Carroll Co., Md.	U.S.A.

13. FATHER'S NAME: Joseph J. Good

14. MOTHER'S MAIDEN NAME: Margaret E. Rogers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
None	None	None	Charles W. Price(husband)	2798 Alameda

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden.

DUE TO

(B) Arteriosclerotic Cardio Vascular Disease — 22-July-'46

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 22-July *1946, to* 10-June *, 1949 that I last saw the deceased alive on* 10-June *, 1949, and that death occurred at* 6 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas W. Edwards M. D.	2746 Alameda	11-June-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June-13-1949	Parkwood Cemetery	Parkville-Balto. Co., Maryland.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR — ADDRESS: Stewart & Mowen Co., 108 W. North Avenue, City #1.

VS 150

93D

G75255

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

55 Registered No. G75255

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Alexander Wenczkowski

2. DATE OF DEATH: 6/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1825 Aliceanna St.
C. Length of stay in Baltimore: 52 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1825 Aliceanna St. 2 03

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3/7/1883
9. AGE (In years last birthday): 66 Yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never if retired): Shoemaker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Victor Wenczkowski
14. MOTHER'S MAIDEN NAME: Eleanor ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Frances Wenczkowski ADDRESS: 1825 Aliceanna St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Biliary tract (Primary)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. I hereby certify that I attended the deceased from April 15 1949 to June 16 1949, that I last saw the deceased alive on June 9, 1949, and that death occurred at 5:00 A m., from the causes and on the date stated above.

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 7349 Eastern Ave.
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/14/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Zeiler, Inc. ADDRESS: 403 S. Wolfe St.

VS 150

46F Baltimore 31, Md.

G75256

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75256

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Try to get correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): John J. Donneman

2. DATE OF DEATH: 9 June 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2223 Bank St.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2223 Bank St. 1-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	12/9/1860	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never if retired): Pipe Fitter
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Donneman
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Helen Beckmann ADDRESS: 2223 Bank St. Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio-Vascular Disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 10 June 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/14/1949	Holy Redeemer Cemetery	Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Lilly & Zeiler, Inc.
ADDRESS: 403 S. Wolfe St, Baltimore 31, Md.

VS 151

937

G75257

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75257

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. correct age is especially important.

1. NAME OF DECEASED (Type or Print): Mr. Charles J. Bouchet

2. DATE OF DEATH: June 11th. 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 11-0
D. STREET ADDRESS (If rural, give location): 206 E. Biddle St. Balto 2.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 5.29.67.
9. AGE (In years last birthday): 82
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Hard~~ LAWYER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John M. Bouchet.
14. MOTHER'S MAIDEN NAME: Elizabeth Brown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Charlotte Bouchet — ADDRESS: 206 E Biddle St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Septicemia.
DUE TO
(B) Prostatitis.
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 3 1949 *to* June 11th 1949 *that I last saw the deceased alive on* June 11th 1949, *and that death occurred at* 2.35 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. J. Castellano M. D.
23B. ADDRESS: Bon Secours Hospital.
23C. DATE SIGNED: June 11-1949.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 14 1949
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: H. H. Weaks & Son — ADDRESS: 805 N. Calvert St.

VS 150

1378

G75258 CERTIFICATE CORRECTED 6-17-49 ✓ X G75258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E915.3

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Prentice Paul ~~MCKINLEY~~ McKinney W-949

2. DATE OF DEATH June 9, 1949

3. PLACE OF DEATH
A. Baltimore City Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Essex
D. STREET ADDRESS (If rural, give location) 318 Poplar Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	May 18, 1900	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John W McKinney
14. MOTHER'S MAIDEN NAME Anna Riggleman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Ellen Marie McKinney ADDRESS Same above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
(A) Severe burns
DUE TO
(B) Traumatic amputation of left arm.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) harbor
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Harbor at the foot of Clinton Street
21D. TIME OF INJURY (Month) 6 (Day) 9 (Year) 49 (Hour) 11a.m.
21E. INJURY OCCURRED WHILE AT WORK ☑ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Explosion of buoy during repair 26/6

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 6/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 13-1949
24C. NAME OF CEMETERY OR CREMATORY Interment
24D. LOCATION (City, town, or county) (State) Pulaski Rd.

DATE RECEIVED BY LOCAL REGISTRAR JUN 13 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR John O'Connelly ADDRESS Essex Md.

VS 151

181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75259

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Oliver S. Best

2. DATE OF DEATH June 10 - 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 134 S. Highland Ave.

C. Length of stay in Baltimore: Yrs. 50 years Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Balto. (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 134 S. Highland Ave.

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 3-27- | 9. AGE (In years last birthday) 55 | If Under 1 Year: Months 2 Days 13 | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never if retired) Guard

10B. KIND OF BUSINESS OR INDUSTRY Prison System

11. BIRTHPLACE (State or foreign country) North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Wilbur Best

14. MOTHER'S MAIDEN NAME Mary Barnett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes | (If yes, give war or dates of service) World War I

16. SOCIAL SECURITY NO.

17. INFORMANT Annie Best | ADDRESS Cabin

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY OCCLUSION — Interval between onset and death: 1 yr.

DUE TO

(B) HYPERTENSION, ESSENTIAL — 2 yrs.

DUE TO

(C) ARTERIOSCLEROSIS, GENERALIZED — 2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) . m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 22 June, 19 49 *to* 10 June, 19 49, *that I last saw the deceased alive on* June 10, 19 49, *and that death occurred at* 10.40 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Benjamin Hollstein M. D. | 23B. ADDRESS 121 S. Highland Ave. | 23C. DATE SIGNED 6/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE June 14-49 | 24C. NAME OF CEMETERY OR CREMATORY Balto. National | 24D. LOCATION (City, town, or county) (State) Frederick Av. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 13 1949 | REGISTRAR'S SIGNATURE Washington Williams, MD | 25. FUNERAL DIRECTOR John G. Connelly | ADDRESS Govt, Md.

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75260

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75260

Registered No.

1. NAME OF DECEASED (Type or Print) HYMAN GARFIELD

2. DATE OF DEATH 6-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in a hospital or institution, give street address or location) 2525 Loyola Southway
c. Length of stay in Baltimore 45 Yrs. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15 13
D. STREET ADDRESS (If rural, give location) 2525 Loyola Southway

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH
9. AGE (In years last birthday) 63
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Lieberman
14. MOTHER'S MAIDEN NAME Sylvia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Rose Garfield ADDRESS 2525 Loyola Southway

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs

DUE TO

(B) Recurrent Coronary Thrombosis — 5 yrs

DUE TO

(C) Atherosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐, NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1944 *to* 6/12 19 49 *that I last saw the deceased alive on* 6/12 19 49 *and that death occurred at* 1039 *m., from the causes and on the date stated above.*

23A. SIGNATURE Rueben B Kline M. D.
23B. ADDRESS 2320 Eutaw Pl
23C. DATE SIGNED 6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6-13-49
24C. NAME OF CEMETERY OR CREMATORY Hebrew Herring Line
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 13 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eutaw Pl

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75261 G75261

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) **Mary Regan**

2. DATE OF DEATH **June 11, 1949**

3. PLACE OF DEATH: A. Baltimore City, Md. **Jenkin's Mem. Hospital**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Jenkin's Memorial Hospital**

C. Length of stay in Baltimore **47 Yrs.** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Jenkin's Mem. Hosp. Balt.** B. COUNTY **(1518 Holbrook)**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore, 29 Md.**

D. STREET ADDRESS (If rural, give location) **1518 Holbrook St. Baltimore, Md.**

5. SEX **F** | 6. COLOR OR RACE **W** | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **S**

8. DATE OF BIRTH **11/5/77** | 9. AGE (In years last birthday) **71** | If Under 1 Year: Months **6** Days **18** | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **(Housewife) (House Maid)**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Ireland**

12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Michael Regan**

14. MOTHER'S MAIDEN NAME **Mary Mahoney**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No**

16. SOCIAL SECURITY NO.

17. INFORMANT **Mrs. Nora Everett** ADDRESS **701 Cathedral St.**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) **Coronary Occlusion Acute**

DUE TO (B) **Hypertension Cardio Vasc. Dis.**

DUE TO (C) **Arteriosclerosis**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY a. m. p. m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **March 4** *, 19* **49** *to* **June 11** *, 19* **49** *that I last saw the deceased alive on* **June 10** *, 19* **49** *and that death occurred at* **2:50** *a. m., from the causes and on the date stated above.*

23A. SIGNATURE **Chas. E. Carr Jr.** M. D. | 23B. ADDRESS **St Agnes Hospital** | 23C. DATE SIGNED **6/11/49**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** | 24B. DATE **6-14-49** | 24C. NAME OF CEMETERY OR CREMATORY **New Cathedral** | 24D. LOCATION (City, town, or county) (State) **Edmondson Avenue, Balto: Md.**

DATE RECEIVED BY LOCAL REGISTRAR **JUN 13 1949** | REGISTRAR'S SIGNATURE **Washington Williams, M.D.** | 25. FUNERAL DIRECTOR **George J. Ruth, Inc.** ADDRESS **1735 Harford Avenue**

VS 150

935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician's correct age is especially important. Please write the cause of death clearly and legibly.

G75262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75262

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lilly Barbara Peacock

2. DATE OF DEATH: 6/11/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Dos Hospital

C. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24-09

D. STREET ADDRESS (If rural, give location): 1602 Webster St

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 2/28/1878 | 9. AGE (In years last birthday): 72 | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Elkton City Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: Sarah Waters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT: William H Peacock | ADDRESS: 1604 Webster

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc.) It means the disease, injury or complication which caused death.) (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Myocardial Failure

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-5-1949 *to* 6-11-1949, *that I last saw the deceased alive on* 6-11-1949 *and that death occurred at* 1015 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Simon Alfon M. D. | 23B. ADDRESS: 2724 N Charles St | 23C. DATE SIGNED: 6-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): B. | 24B. DATE: 6/14/49. | 24C. NAME OF CEMETERY OR CREMATORY: Baeto Kat. | 24D. LOCATION (City, town, or county) (State): 556 Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949 | REGISTRAR'S SIGNATURE: Clayton Williams, MD | 25. FUNERAL DIRECTOR: Jno L. McCauley | ADDRESS: 1130 E. Fort Ave 83a

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and fully.

G75263

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75263

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and correct age is especially important.

MEDICAL CERTIFICATION

1. NAME OF DECEASED (Type or Print): AUGUSTA DAUS

2. DATE OF DEATH: 6/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — 1510 Locust St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1510 Locust Street 25-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	W	1873	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Family — ADDRESS: above

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
(A)	Arteriosclerotic Cardio-vascular disease	
DUE TO		
(B)		
DUE TO		
(C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Terminal Bronchopneumonia — 2 weeks

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 15, 1949, to June 11, 1949, that I last saw the deceased alive on June 6, 1949, and that death occurred at 10 A.M., from the causes and on the date stated above.

23A. SIGNATURE: Sidney R. Filbert, M. D.
23B. ADDRESS: 4700 Penning Toy Ave
23C. DATE SIGNED: 6/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	6/14/49	Cedar Hill	Brooklyn

DATE RECEIVED BY LOCAL REGISTRAR: JUN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Dugan Funeral Co.
ADDRESS: 130 E. Fort Ave.

VS 150

937

G75264
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

5-600 G75264
Registered No.

1. NAME OF DECEASED (Type or Print) JAMES W. STANEK

2. DATE OF DEATH 6-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL
C. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 27-01
D. STREET ADDRESS (If rural, give location) 4024 RIDGE-CROFT RD #6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	6-6-1900	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) PRINTER
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME FRANK STANEK
14. MOTHER'S MAIDEN NAME ANTONIA YANDA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ROSE C STANEK ADDRESS 4024 RIDGECROFT RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) CEREBRAL ANOXIA CIRCULATORY COLLAPSE — 5 days
DUE TO
(C) SODIUM PENTOTHAL — over 5 days.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 6-8-49
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-7, 1949 to 6-12, 1949 that I last saw the deceased alive on 6-12, 1949, and that death occurred at 1:15 P m., from the causes and on the date stated above.

23A. SIGNATURE [signature] M. D.
23B. ADDRESS Maryland Surgical Group
23C. DATE SIGNED 6-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6-15-49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 13 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR L J Luck
ADDRESS 5305 Harford Rd

VS 150

122a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physician: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#43

G75265 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sister Mary Ethelberta

2. DATE OF DEATH 6/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. Length of stay in Baltimore Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-7
D. STREET ADDRESS (If rural, give location) St. Paul's Convent, N. Caroline Street

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH 1-19-80

9. AGE (In years last birthday) 69

If Under 1 Year: Months / Days

If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use if retired) Religious

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ireland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT St. Pauls Convent ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Spontaneous Subarachnoid Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio-Vascular Disease

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/10/49, 19__, to 6/13/49, 19__, *that I last saw the deceased alive on* 6/13/49, 19__, *and that death occurred at* 1:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Paul Russo Jr. M. D.

23B. ADDRESS 1400 N. Caroline St.

23C. DATE SIGNED 6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried

24B. DATE 6-17-49

24C. NAME OF CEMETERY OR CREMATORY Glen Rubble

24D. LOCATION (City, town, or county) (State) Pa

DATE RECEIVED BY LOCAL REGISTRAR JUN 13 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR D. J. Luck

ADDRESS 5305 Harford Rd. 14

VS 150

937

G75266

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75266

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Ernest D. Wessel

2. DATE OF DEATH May 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 7004 Harford Rd 27-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	M	Nov 6, 1898	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William J. Wessell
14. MOTHER'S MAIDEN NAME Eudora Atkinson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Gladys Wessel ADDRESS 7004 Harford Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Colloid Carcinoma with metastases

DUE TO

ANTECEDENT CAUSES
(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized debilitation

INTERVAL BETWEEN ONSET AND DEATH: 4-5 years over

19A. DATE OF OPERATION 5-9-49
19B. MAJOR FINDINGS OF OPERATION Carcinoma with metastases
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 29, 1949, to June 10, 1949 *that I last saw the deceased alive on* June 10, 1949, *and that death occurred at* 10:50 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE John M. Buchness M. D.
23B. ADDRESS Mercy Hospital
23C. DATE SIGNED 6-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6-14-49
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 13 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Leonard J. Funk ADDRESS 5305 Harford

VS 150

469

G75267 CERTIFICATE CORRECTED 6-16-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75267 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Rosalie M Christian (Christina)

2. DATE OF DEATH: June 10 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3324 Ravenwood Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 55 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3324 Ravenwood Ave

5. SEX: Female | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed | 8. DATE OF BIRTH: Oct 10 1886 | 9. AGE (In years last birthday): 62 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): housewife | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Germany | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Felix Hombeck | 14. MOTHER'S MAIDEN NAME: Anna Sadajewska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Elizabeth Derda | ADDRESS: 3324 Ravenwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Stomach — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive Cardio Vascular Disease

DUE TO

(C) Cardiac Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: — | 19B. MAJOR FINDINGS OF OPERATION: — | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): — | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): — | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?: —

22. I hereby certify that I attended the deceased from Sept. 1947 to June 1949, that I last saw the deceased alive on June 9 1949, and that death occurred at 2 10 A m., from the causes and on the date stated above.

23A. SIGNATURE AND TITLE OF CERTIFYING PHYSICIAN: [illegible] M. D. | 23B. ADDRESS: 2711 Eutaw Ave. | 23C. DATE SIGNED: 6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: June 13/49 | 24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus | 24D. LOCATION (City, town, or county) (State): Dundalk Ave Md

RECEIVED BY LOCAL REGISTRAR: [illegible] 1949 | REGISTRAR'S SIGNATURE: [illegible] | 25. FUNERAL DIRECTOR: John J. Dida | ADDRESS: 2829 Hudson St

VS 150

460

G75268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

241 Registered No. G75268

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Benjamin F. Riley

2. DATE OF DEATH: 6-11-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-14
D. STREET ADDRESS (If rural, give location): 1049 Roland Heights Ave

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 21-1888

9. AGE (In years last birthday): 60 (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butler Fireman

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin F. Riley

14. MOTHER'S MAIDEN NAME: Catherine Bearman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 210-07-6185

17. INFORMANT: Mrs. Bertha Riley ADDRESS: 1049 Roland Hgts

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc., but means the disease, injury or complication which caused death.)

(A) Cardiac decompensation

DUE TO

(B) Bronchial Asthma

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* 6/11, 1949, to 6/11, 1949, *that I last saw the deceased alive on* 6/11, 1949, *and that death occurred at* 5:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Frank Burgee III M. D.

23B. ADDRESS: Union Memorial Hosp

23C. DATE SIGNED: 6/11/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: June 14-1949

24C. NAME OF CEMETERY OR CREMATORY: Woodlawn

24D. LOCATION (City, town, or county) (State): Baltimore Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 7 1949

REGISTRAR: Williams, M.D.

25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 325 Stockholm

VS 150

95c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and correct age is especially important.

G75269 ✓ 331 G75269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Delcie J. Wiles

2. DATE OF DEATH: June 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ardleigh Nursing Home 2075 Lochrose Avenue
C. Length of stay in Baltimore: 37 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3505 Buena Vista Avenue 13-18

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 30, 1873
9. AGE (In years last birthday): 75 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Richard M. King
14. MOTHER'S MAIDEN NAME: Sue ---
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: William B. Wiles ADDRESS: 3505 Buena Vista Avenue.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and correct age is especially important.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc., but means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 17 days
DUE TO
(B) Hypertension — 1 Yrs?
DUE TO
(C) Renal Arteriosclerosis — ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY. (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 9, 1949 *to* June 12, 1949, *that I last saw the deceased alive on* June 11, 1949, *and that death occurred at* 4:50 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jonas H. Cohen M. D.
23B. ADDRESS: 5901 Park Hgts. Ave.
23C. DATE SIGNED: 6/13/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 14, 1949
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Baltimore Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949
REGISTRAR: Registrar for Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

VS 150

83a

G75270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75270

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs Mary A. Lowman.

2. DATE OF DEATH June 11 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland B. Baltimore City Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital.

c. Length of stay in Baltimore: ? yrs Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2729 Wilkens Ave. 20-05

5. SEX Female | 6. COLOR OR RACE Wht | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 3-31-1871 | 9. AGE (In years last birthday) 78 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland. | 12. CITIZEN OF WHAT COUNTRY? -

13. FATHER'S NAME James [illegible]ell

14. MOTHER'S MAIDEN NAME Catherine Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. ?

17. INFORMANT Hosp. Records ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc., but means the disease, injury or complication which caused death.)

(A) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Arteriosclerotic heart disease ? yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia, hypostatic, left lower lobe approx 2 wks

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 5 1949 *to* June 11 1949 *that I last saw the deceased alive on* June 11 1949 *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Herbert J. Kirckos M. D. | 23B. ADDRESS St. Agnes Hospital | 23C. DATE SIGNED 6/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 6/15/1949 | 24C. NAME OF CEMETERY OR CREMATORY Cathedral | 24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 15 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Flynn & Fleming | ADDRESS 1426 Light St.

937

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75271

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Please write the correct age is especially important. Physician: please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

1. NAME OF DECEASED (Type or Print): WILLIAM T. BROWN

2. DATE OF DEATH: June 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1714 De Soto Rd.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1714 De Soto Rd. 25-52

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan. 10, 1874
9. AGE (In years last birthday): 75 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired Park Police
10B. KIND OF BUSINESS OR INDUSTRY: Baltimore City
11. BIRTHPLACE (State or foreign country): Chestertown, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Brown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Beulah J. Brown
ADDRESS: 1714 DeSoto Rd.

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Thrombosis	48 hours
DUE TO	(B)	
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE? HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1949 *to* May, 1949 *that I last saw the deceased alive on* May 15, 1949 *and that death occurred at* 2 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Morris W. Steinberg M. D.
23B. ADDRESS: 410 N. Hilton St
23C. DATE SIGNED: June 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/15/49
24C. NAME OF CEMETERY OR CREMATORY: Balto. National Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949
REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

94a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75272 (1/51) Registered No. G75272

BIRTH NO. G75272

1. NAME OF DECEASED (Type or Print) WILLIAM FRANKLIN DERR

2. DATE OF DEATH June 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3502 Clifton Ave.
Fotterhill Nursing Home
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3302 Alto Rd. 15-37

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widowed	Sept. 29, 1880	68 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier
10B. KIND OF BUSINESS OR INDUSTRY: Sheraton Belvedere Hotel
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Theodore Derr
14. MOTHER'S MAIDEN NAME: Anna Crouse
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-03-7639
17. INFORMANT: Mr. William Keefer Derr ADDRESS 3317 Liberty Heights

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory failure
DUE TO
(B) Carcinoma Stomach
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Cardiovascular revealed

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) June 13, 1949 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1944, to June 12, 1949 that I last saw the deceased alive on June 10, 1949, and that death occurred at 12.10 A.m., from the causes and on the date stated above.

23C. SIGNATURE J. Abrahams M. D. M. D.
23B. ADDRESS 601 N. Monroe St
23E. DATE SIGNED 6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/15/49
24C. NAME OF CEMETERY OR CREMATORY Westminster Cem
24D. LOCATION (City, town, or county) (State) Westminster, Md.

DATE REGISTERED LOCAL REGISTRAR JUN 14 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR WM. J. TICKNER & SONS
ADDRESS Balto., Md.

VS 150

46B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G75273 ✓ X G75273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 143

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Agnes Viola Jordan

2. DATE OF DEATH June 11th.

3. PLACE OF DEATH
A. Baltimore City, Maryland St. Agnes Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pasadena.
D. STREET ADDRESS (If rural, give location) Rock View Beach

5. SEX Female | 6. COLOR OR RACE W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH 8-20-1878 | 9. AGE (In years last birthday) 70 | If Under 1 Year: Months, Days | If Under 1 Day: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland (Balto.) | 12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Andrew G. Dodson

14. MOTHER'S MAIDEN NAME Frances L. Reynolds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly, and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Multiple Embolic arteriosclerotic
DUE TO
(B) Hypertensive C.V. Disease
DUE TO
Auricular Fibrillation; Cardiac Decompensation;
(C) Gangrene Rt. Leg.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 6/9/49 | 19B. MAJOR FINDINGS OF OPERATION Dry Gangrene - Rt. leg. | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/8/49, 1949 to 6/11, 1949 that I last saw the deceased alive on 6/11, 1949, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

23A. SIGNATURE Walter Bernard M.D. | 23B. ADDRESS St. Agnes' Hospital | 23C. DATE SIGNED 6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 6/14/49 | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | 24D. LOCATION (City, town, or county) Balto., Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR JUN 13 1949 | SIGNATURE OF REGISTRAR [illegible] | 25. FUNERAL DIRECTOR Wm. J. TICKNER & SONS | ADDRESS Balto., Md.

VS 150

937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G75274 Registered No. G75274

1. NAME OF DECEASED (Type or Print): Sewell Nina Coleman

2. DATE OF DEATH: 6/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 530 N. Calhoun St
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 530 N. Calhoun St. 19-01

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Mar. 16, 1873
9. AGE (In years last birthday): 76 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Taylorsville, Md.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Henry Franklin
14. MOTHER'S MAIDEN NAME: Clementine Barnes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Joseph Dressel ADDRESS: 6206 Birchwood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteriosclerotic CV disease	
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE (WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR
23C. DATE SIGNED: 6/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 14, 1949
24C. NAME OF CEMETERY OR CREMATORY: Taylorsville Meth. Cem.
24D. LOCATION (City, town, or county) (State): Taylorsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949
REGISTRAR'S SIGNATURE: [signature] Taylorsville, Md.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS-15T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

93D

G75275 ✓ G75275

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ELIZABETH W. WATTS

2. DATE OF DEATH: June 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 929 N. Bentalou St.

C. Length of stay in Baltimore: 25 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 929 N. Bentalou St. 1615

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: May 24, 1884
9. AGE (In years last birthday): 65 yrs. (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Richmond, Va.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Richard H. Jordon

14. MOTHER'S MAIDEN NAME: Elizabeth Gille

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war, or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Herbert G. Stevens - ADDRESS: 929 N. Bentalou

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the cause of death clearly and legibly. Physician: please write correct age if especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc., but means the disease, injury or complication which caused death.)

(A) Coronary Heart Disease — Interval between onset and death: 4 years

DUE TO

(B) Coronary Sclerosis — 4 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1948 *to* June 10, 1949 *that I last saw the deceased alive on* June 10, 1949, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. Mendelis M. D.
23B. ADDRESS: 651 N Bentalou
23C. DATE SIGNED: 6/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/13/49
24C. NAME OF CEMETERY OR CREMATORY: Western Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS - ADDRESS: Balto., Md.

94a

G75276 Peisinger 443 G75276

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Frances Peisinger

2. DATE OF DEATH June 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Little Sisters of the Poor Home for the aged
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1200 Valley St 10-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W.	W	March 9, 1874	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joseph Feigl
14. MOTHER'S MAIDEN NAME Antoinette —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Sister Ignatius ADDRESS 1200 Valley St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hypertensive Cardio Vascular	3 yrs
DUE TO	Disease -	
(B)	Arteria Sclerosis	5 yrs -
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Jan 5, 1949, *to* June 12, 1949, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 10 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE E Gill Hall M. D.
23B. ADDRESS 1631 E Monument Ave
23C. DATE SIGNED June 13-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 14 49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR JUN 13 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR Rita Wiedefeld
ADDRESS 900 E. Biddle St

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G75[illegible]7 — Registered No. 10. 1. G7527

1. NAME OF DECEASED (Type or Print): Edward C. Moran — 2. DATE OF DEATH: 6/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryl[illegible]
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South [illegible]ltimore General
C. Length of stay in Balti[illegible]re: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2669 Edmondson Ave. 20-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	5/4/82	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard
10B. KIND OF BUSINESS OR INDUSTRY: Marintime Com.
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Paterick Moran
14. MOTHER'S MAIDEN NAME: Mary Dolan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Dorothy Moran 2669 Edmondson Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc.—it means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE (ACCIDENT, SUICIDE, HOMICIDE) PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE [illegible] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 12 Jun 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/14/49	New Cathedral	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR — ADDRESS: J. T. Stansbury 2700 Edmondson Ave.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

94a

CERTIFICATE CORRECTED 6-23-49 ✓

G75278 — G75278

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17° Registered No.

1. NAME OF DECEASED (Type or Print): Winifred Jenkins

2. DATE OF DEATH: 6-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore Gen. Hospital
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-05
D. STREET ADDRESS (If rural, give location): 2525 Arunah Ave #15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
F	W	Widow	2-1-94	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	USA

13. FATHER'S NAME: Martin J. Connolly

14. MOTHER'S MAIDEN NAME: Anna McDonough

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr Edward Jenkins	2525 Arunah Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Metastatic Carcinoma

DUE TO
(B) from Carcinoma of Breast.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-28-49, 19__, *to* 6-13-49, 19__, *that I last saw the deceased alive on* 6-13-49, 19__, *and that death occurred at* 1:55 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
B. L. Grant M.D. M. D.	West Baltimore Gen. Hosp.	6-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/16/49	New Cathedral Cem.	4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 13 1949	Cunningham Williams M.D.	John J. Cowan & Son	Pollen St

VS 150

50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75279

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75279

1. NAME OF DECEASED (Type or Print) — seph Moss

2. DATE OF DEATH — June 13 1949

3. PLACE OF DEATH:
A. Baltimore City, Mary[illegible] — 4009 Elderon Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Balt[illegible]e — I — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY
c. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 4009 Elderon Ave. 28 a1

5. SEX Male — 6. COLOR OR RACE White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married — 8. DATE OF BIRTH Feb. 19 1881 — 9. AGE (In years last birthday) 68 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired — 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Moss

14. MOTHER'S MAIDEN NAME Rachel Schless

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Dorothy Lipnick ADDRESS 4009 ElderonAve

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc., it means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B) Arteriosclerosis
DUE TO
(C) Hypertension

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location.)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 1948 *to* June 13, 1949, *that I last saw the deceased alive on* June 13, 1949, *and that death occurred at* 12 44 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Daniel J Schwartz M. D. — 23B. ADDRESS 2320 Eutaw Place — 23C. DATE SIGNED June 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE June 14, 1949 — 24C. NAME OF CEMETERY OR CREMATORY Hebrew Rosedale Cem — 24D. LOCATION (City, town or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 13 1949 — REGISTRAR'S SIGNATURE [illegible] Williams, M.D. — 25. FUNERAL DIRECTOR Sol Levinson & Bros — ADDRESS 1126 W North AVE

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians please write the cause of death clearly and legibly.

CERTIFICATE CORRECTED 6-13-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75280

G75280 129513

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Albert Watson.

2. DATE OF DEATH June 10,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1823 McCulloh ST. Z 17

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 12, 1895 1896
9. AGE (In years last birthday) 53 Yrs. 0 Months 0 Days 0 Hours 0 Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Watson
14. MOTHER'S MAIDEN NAME Nettie Frazier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Records Baltimore City Hospitals ADDRESS 4940 Eastern

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Allergic reaction to local anaesthesia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Right upper lobe lung abscess

CERTIFICATION APPROVED BY
A. A. Merrill M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION June 10,1949.
19B. MAJOR FINDINGS OF OPERATION Bronchoscopy
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Baltimore City Hospitals
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore City Hospitals
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) June 10-1949 11 A.m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Allergic reaction to local anaesthesia

22. *I hereby certify that I attended the deceased from* June 8, 1949 *to* June 10, 1949 *that I last saw the deceased alive on* June 10, 1949 *and that death occurred at* 11.00 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS 4940 Eastern Ave B.C.H.
23C. DATE SIGNED June 10, 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 1949
24C. NAME OF CEMETERY OR CREMATORY Family Lot
24D. LOCATION (City, town, or county) (State) Catonsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 7 1949
REGISTRAR'S SIGNATURE [signature]
25. FUNERAL DIRECTOR Holland Funeral Home ADDRESS 1631 Druid Hill Ave.

VS 150

TO BE APPROVED BY THE MEDICAL EXAMINER.

114D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

CERTIFICATE CORRECTED 6-15-49.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75281 — Registered No. G75281

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Bethea — N-86.1.4 — 2. DATE OF DEATH: 6/11/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 6/11/49

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.O.A. — UNIVERSITY HOSPITAL

c. Length of stay in Baltimore: about 20 Yrs. 4m Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. — Md.
D. STREET ADDRESS (If rural, give location): 908 Fremont Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	Col.	Married	1893	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer — 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Fla. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown — 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.

17. INFORMANT: Brother Bethea — ADDRESS: 908 Fremont

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and forcibly.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc., it means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Bullet Wound of Chest

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE (Accident, Suicide, Homicide) PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): In front of 318 N. Pearl Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 12, 1949 12:15 p.m.

21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I [illegible] charge of the remains described above, held an* Autopsy *thereon and from* Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE: [signature] M.D. — 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ — 23C. DATE SIGNED: 12 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 6/14/49 — 24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn — 24D. LOCATION (City, town, or county) (State): West post Balto

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Metropolitan Funeral Home Inc. — ADDRESS

166

VS 151

G75282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443

Registered No. G75282

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MAGGIE MILLER (MAGGIE TUCKER MILLER)

2. DATE OF DEATH June 11, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2014 Rayner Avenue
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 2014 Rayner Avenue 16-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored			50	11	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
? Tucker, Virginia

14. MOTHER'S MAIDEN NAME
Marden Vina Cavanos — Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
John Carrington, 1138 N. Gilmore St.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Thos. G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED June 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/16/49	Alberta Va.	Va.

DATE RECEIVED BY LOCAL REGISTRAR JUN 13 1949

REGISTRAR'S SIGNATURE [illegible] Washington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS
Metropolitan Funeral Home Inc 937

VS 151

G75283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75283

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clifton R. Cable

2. DATE OF DEATH 6-11-49

3. PLACE OF DEATH: A. Baltimore City, Maryland B. BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4616 York Rd

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE

D. STREET ADDRESS (If rural, give location) 4616 York Rd 27-11

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH July 18, 1878 | 9. AGE (In years last birthday) 70 | If under 1 Year: Months Days | If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY Post Office

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Cable

14. MOTHER'S MAIDEN NAME Virginia Lee Reynolds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Virginia C. White ADDRESS 4616 York Rd

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the cause of death clearly and legibly. If age is especially important, Physician please write

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive-Cardio-Vascular Renal disease — INTERVAL BETWEEN ONSET AND DEATH: 5 YRS.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Hydrocele - left. — 6 Y/O

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Possible Carcinoma of Stomach — 6 MO.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 17, 1947, *to* June 11, 1949, *that I last saw the deceased alive on* June 10, 1949, *and that death occurred at* 6:20 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Lloyd E. Taylor M. D. 23B. ADDRESS 3902 Greenmount Ave.

23C. DATE SIGNED June 14 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE 6-14-49

24C. NAME OF CEMETERY OR CREMATORY BALTIMORE

24D. LOCATION (City, town or county) (State) BALTIMORE Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 13 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR John A. Moran ADDRESS 3000 Balt. St

1310

BIRTH NO. G75284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75284

1. NAME OF DECEASED (Type or Print): Elizabeth Pinkett Williams

2. DATE OF DEATH: June 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 509 S. Paca

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maryland
D. STREET ADDRESS (If rural, give location): 509 S. Paca

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Widow	1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): A. A. Co., Md.

12. CITIZEN OF WHAT COUNTRY? USa

13. FATHER'S NAME: William Lee

14. MOTHER'S MAIDEN NAME: Mary Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war, or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Benny (Benjamin) Boone Magothy, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of breast
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: June 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 12 49
24C. NAME OF CEMETERY OR CREMATORY: Magothy.
24D. LOCATION (City, town, or county) (State): A.A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.

25. FUNERAL DIRECTOR: James A Dailey
ADDRESS: 142 W Hill 50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75285 Dr. Janny

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 Registered No. G75285

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John J. Sweeney

2. DATE OF DEATH: Junell, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6040 Harford Road
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6040 Harford Road 7-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
male	white	married	Dec. 19-1901	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John J. Sweeney
14. MOTHER'S MAIDEN NAME: Margaret Regan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Mildred Sweeney, ADDRESS: 6040 Harford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma, Oesophagus — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: March 1949
19B. MAJOR FINDINGS OF OPERATION: Carcinoma, oesophagus
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1949 to June 11, 1949 that I last saw the deceased alive on June 11, 1949 and that death occurred at 7:45 P. m., from the causes and on the date stated above.

23A. SIGNATURE: Nathan Janney M. D.
23B. ADDRESS: 7101 Harford Rd.
23C. DATE SIGNED: 6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-14-49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Ruck, ADDRESS: 5305 Harford Road.

VS 150

46a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

G75286

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3-31

G75286

Registered No.

1. NAME OF DECEASED (Type or Print): MYRTLE THOMPSON BRAUER

2. DATE OF DEATH: June 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 601 McCabe Avenue

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 601 McCabe Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	June 15, 1892	56 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Charles R. Merg

14. MOTHER'S MAIDEN NAME: Ella Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Wm. H. Brauer Sr. — ADDRESS: 601 McCabe Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 4 HOURS

DUE TO

(B) ESSENTIAL HYPERTENSION — 20 YEARS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HYPERTENSIVE HEART DISEASE 10 YEARS

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/1 1946 *to* 6/11, 1949, *that I last saw the deceased alive on* 6/10, 1949, *and that death occurred at* 7.15 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 6331 Belair Rd. (6)

23C. DATE SIGNED: 6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/14/49	Greenmount Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 13 1949

REGISTRAR'S SIGNATURE: [signature]

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75287

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75287

Registered No.

1. NAME OF DECEASED (Type or Print): HARRY S GRAPE

2. DATE OF DEATH: 12 June 49

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSP.

c. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 27-48
D. STREET ADDRESS (If rural, give location): 600 & Clear Spring RD.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 29 July 74
9. AGE (In years last birthday): 74 (If under 1 Year: Months 10, Days 13; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto MD
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Winfield Scott Grape
14. MOTHER'S MAIDEN NAME: Ella Richardson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-04-1671

17. INFORMANT: Patient ADDRESS:

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc.) It means the disease, injury or complication which caused death.)
(A) lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 23 May 1949 to 12 June 1949 that I last saw the deceased alive on 12 June 1949, and that death occurred at 11:45 P.m., from the causes and on the date stated above.

23A. SIGNATURE: John A Ferris M. D.
23B. ADDRESS: Mercy Hosp.
23C. DATE SIGNED: 13 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 15/49
24C. NAME OF CEMETERY OR CREMATORY: Montfond Park
24D. LOCATION (City, town, or county) (State): Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 14 1949
REGISTRAR'S SIGNATURE: Lillington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St

VS 150

55E

G75288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75288

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK M. EVERLEY

2. DATE OF DEATH June 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1815 Dover St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1815 Dover St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Seperated	Nov. 24, 1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Auto Mechanic	Exhaust Rug Cleaners	Maryland	

13. FATHER'S NAME: Albert Everley

14. MOTHER'S MAIDEN NAME: Anna Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	World No 1	213-14-0453	Dorothy Reeb	1813 Dover St., Baltimore, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardiac disease — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) —
DUE TO
(C) Terminal pneumonia bronchopneumonia — 3 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from 6-9-1949 to 6-11-1949 that I last saw the deceased alive on 6-9-1949 and that death occurred at 11:55 Am., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Morris B. Schreiber M.D.	54 S. Fulton Ave.	6-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 6/15/49	National	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR 6-14-49 REGISTRAR [illegible]

25. FUNERAL DIRECTOR ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 150

937

G75289

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

177 Registered No. G75289

1. NAME OF DECEASED (Type or Print) MARTIN J. RHEIN

2. DATE OF DEATH June 12,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1218 Brentwood Ave.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1218 Brentwood Ave. 10-01

5. SEX	6. COLOR	6. RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	If under 1 Year: Days	If under 24 Hours: Hours	If under 24 Hours: Min.
Male	White		Married	Feb.21,1875	74				

10A. USUAL OCCUPATION (Kind of work done during most of working life. If retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Transfer Trucking	Retired	Germany	

13. FATHER'S NAME George J. Rhein

14. MOTHER'S MAIDEN NAME Elizabeth vonHoelden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Mrs Madeline R. Rhein	1218 Brentwood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
(A)	Carcinoma of Prostate	6 mo.
DUE TO		
	ANTECEDENT CAUSES	
(B)		
DUE TO	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
(C)		
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that, I attended the deceased from* Feb. 6, 1949 *to* June 12, 1949, *that I last saw the deceased alive on* June 12, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph L. Blum M.D.	115 N. Calvert St.	6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/15/49	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 14 1949	[illegible]	William Cook, Inc.,	1217 St. Paul St.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physician please write the cause of death clearly and legibly.

51B

G-75290

G-75290

G-75290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 75290

BIRTH NO. 75290

1. NAME OF DECEASED (Type or Print): ANNA MARGARET BAUER

2. DATE OF DEATH: June 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals

c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1010 S. Conkling Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married - Sep.	Jan. 9, 1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at Home	self	Maryland	-

13. FATHER'S NAME: Frederick Fristenman

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
-	-

17. INFORMANT: Records, Baltimore City Hospitals — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc.) It means the disease, injury or complication which caused death.)

(A) Cardio Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis, Generalized
Chr. Passive Congestion of Lungs & Liver.

19A. DATE OF OPERATION: -

19B. MAJOR FINDINGS OF OPERATION: -

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): -

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): -

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): -

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: -

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?: -

22. *I hereby certify that I attended the deceased from* June 4, 1939 *to* June 12, 1949 *that I last saw the deceased alive on* June 12, 1949 *and that death occurred at* 8:50P *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 4940 Eastern Avenue

23C. DATE SIGNED: 6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 16, '49	Oak Lawn Cem.	Eastern Avenue, Ext.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
June 14, '49	Huntington Williams, M.D.	Wm. Cook, Inc., 1217 St. Paul St.

VS 150

97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the cause of death clearly and legibly.

BIRTH NO. 75291

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

539.1 G75291 Registered No.

1. NAME OF DECEASED (Type or Print) HARRY NELSON MC ROBERTS

2. DATE OF DEATH June 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pa.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montrose
D. STREET ADDRESS (If rural, give location) RFD #3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	10/4/01	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Radio operator	Seafarer	Michigan	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Mc Roberts	Evelina Wills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown	Unknown	Records- US Marine Hospital, Balto, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) 1- Esophagopleural fistula following plastic repair of congenitally short esophagus on 5/27/49

DUE TO (B) 2- Acute pericarditis

DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
5/27/49	Shortening of esophagus with stenosis	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* May 2, 1949, *to* June 13, 1949, *that I last saw the deceased alive on* June 13 1949, *and that death occurred at* 5:15P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M.D.	US Marine Hospital, Balto, Md.	6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/17/49	Franklin Fork Cem	Susquehanna Co. Penna

DATE RECEIVED BY LOCAL REGISTRAR JUN 14 19 [illegible] REGISTRAR'S SIGNATURE [illegible]

25. FUNERAL DIRECTOR Charles P. Towell ADDRESS 2437 Edmondson Ave

VS 150

116

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

503774

55292
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75292
Registered No.

1. NAME OF DECEASED (Type or Print): Wade Stevens

2. DATE OF DEATH: JUN 12 1949

3. PLACE OF DEATH: a. Baltimore City, Md. Osler - 2

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 7 — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 23 01
d. STREET ADDRESS (If rural, give location): 166 West, St. W.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	single	12-6-25	23		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Henry Stevens
14. MOTHER'S MAIDEN NAME: Charity Houser
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis c Cavitation.. — Interval between onset and death: Months.

DUE TO

(B) Pelvic Abcess. + peritonitis due to tuberculosis — Months.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-8- 1949 *to* 6-12- 1949 *that I last saw the deceased alive on* 6- 1949 *and that death occurred at* 11 50 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Anthony J. Dee M. D.
23b. ADDRESS: JOHNS HOPKINS HOSPITAL
23c. DATE SIGNED: 6-13-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 6 7 1949
24c. NAME OF CEMETERY OR CREMATORY: Smithfield N C
24d. LOCATION (City, town, or county) (State): North Carolina

DATE RECEIVED BY LOCAL REGISTRAR: JUN 14 1949
REGISTRAR SIGNATURE: Registrar for Williams, M.D.
25. FUNERAL DIRECTOR: L. L. Brown Sons ADDRESS: 108 W Montgomery St

VS 150

13B

G75293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75293

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret Lee Rinaca

2. DATE OF DEATH June 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 21 S. Potomac St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

C. Length of stay in Baltimore about 10 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Virginia
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Virginia
D. STREET ADDRESS (If rural, give location) Virginia

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	June 13, 1865	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Hepner

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT Mrs. Cleopatora Loudenback ADDRESS 21 S. Potomac St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mons.

DUE TO

(B) arteriosclerotic cardiovascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. embolism & hemiplegia right

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/16, 1949, to 6/13, 1949, that I last saw the deceased alive on 6/13, 1949, and that death occurred at 5 P. m., from the causes and on the date stated above.

23A. SIGNATURE, M.D.	23B. ADDRESS	23C. DATE SIGNED
Stanley B. Klyanowicz	3500 Eastern Ave	6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 16 49	St. Paul Church Cemetery Shenandoah	Shenandoah Virginia

DATE RECEIVED BY LOCAL REGISTRAR: JUN 14 1949

REGISTRAR'S SIGNATURE: John Williams, M.D.

FUNERAL DIRECTOR: S. Walter May ADDRESS: 6194 N. Boulevard

VS 150

937

G75294

G75294

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

143 Registered No.

1. NAME OF DECEASED (Type or Print) EMMA BREEBACH

2. DATE OF DEATH 6/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6028 Old Harford Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Beech Hill Nursing Home

c. Length of stay in Baltimore Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City

D. STREET ADDRESS (If rural, give location) 3814 Southern Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	white	widow	Aug. 8th, 1880	68	10	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Md.	U.S.A.

13. FATHER'S NAME Jacob Schlegel

14. MOTHER'S MAIDEN NAME Bertha Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. Rudolph Breebach	5012 Morella Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean mode of dying, e.g., heart failure, asthenia. It means the disease, injury or complication which caused death.)	(A) Hypertensive Arteriosclerotic C.V.D.	
ANTECEDENT CAUSES	DUE TO (B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Carbuncle of lumbar region as intercurrent basis	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov., 1947, *to* June, 1949, *that I last saw the deceased alive on* June 11, 1949, *and that death occurred at* 6.45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. W. Hagen M.D. M. D.	4718 Harford Rd.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	6/15/49	Parkwood	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 14 1949	Clayton Williams, M.D.	Lassahn Funeral Home	7401 Belair Rd.

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75295

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75295 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Valenza

2. DATE OF DEATH June 13-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 742 Pennsylvania Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 50 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-01
D. STREET ADDRESS (If rural, give location) 742 Pennsylvania ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Nov 17-1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY: Fruit Dealer

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Valenza

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Daniel Valenza ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Renal — INTERVAL BETWEEN ONSET AND DEATH: 10 years

DUE TO

(B) Uremia Poisoning.

DUE TO

(C) Myocardial Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 11, 1949, *to* June 13, 1949 *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	1402 Cathedral St. Balto.	June 15-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 16-1949	New Cathedral Cemetery	Old Frederick Rd. Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 14 1949

REGISTRAR'S SIGNATURE: [signature] Catonsville, Md.

25. FUNERAL DIRECTOR: Joseph Farace Inc. ADDRESS: 2013 Freemont Ave

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physician please write the cause of death clearly and legibly.

131a

G75296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75296 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forest Ave.
(c) Hospital or institution: Maryland Penitentiary Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. Stone Ave. Alley 7 - 1 (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Jefferson Moore

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race Black
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife Louise Bolden (Dec'd)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1890

8. AGE: Years 58 Months 7 Days 3 If less than one day hr. min.

9. Birthplace Gaston, N.C. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Wilson Moore
13. Birthplace Gaston, N.C.

MOTHER
14. Maiden Name Priscilla Shanks
15. Birthplace Jacksonville, Florida

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 14 49 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Govans Hill Rd
18 (a) Funeral director J. J. Casey & Sons
(b) Address 1310 Light St. Washington Boulevard
19 (a) JON 13 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1949 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death	Duration
Acute Pulmonary Edema	
Due to Chronic Pulmonary Fibrosis & Bronchopneumonia	
Due to Recurrent non-specific bronchitis	
Other Conditions Cor Pulmonale Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence? at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry W. D. Kolbe M. D.
Address Date signed 6-9-49

VS 150

107

Every item of information should be carefully ... The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

BIRTH NO. G75:297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

140 Registered No. G75:297

1. NAME OF DECEASED (Type or Print): James Seward

2. DATE OF DEATH: 6-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Edgewood Nursing Home
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Woodstock
D. STREET ADDRESS (If rural, give location):

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: 1860
9. AGE (In years last birthday): 89 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cambridge, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Seward
14. MOTHER'S MAIDEN NAME: Mary Eliz. Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Thomas Seward, ADDRESS: Woodstock, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Ca Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 1 Month

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B) Carcinoma of Lower Gi. Tract — 1 Year
DUE TO (C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 31 1948 *to* June 13 1949, *that I last saw the deceased alive on* June 13, 1949, *and that death occurred at* 12 M. p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: 112 W. 25th St.
23C. DATE SIGNED: June 14, 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-16-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. View
24D. LOCATION (City, town, or county) (State): Alpha, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: F.C. Higinbotham, ADDRESS: Ellicott City, Md.

VS 150

45a

G75298

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

002 Registered No. G75298 335337

1. NAME OF DECEASED (Type or Print) Andrew STANCO

2. DATE OF DEATH 6-13-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Delta - Md

D. STREET ADDRESS (If rural, give location) Spring street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	white	widower	1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Theodor Stanco

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Walter Stanco ADDRESS 1507 Aisquith St Baltimore

MEDICAL CERTIFICATION

Every item of information should be carefully supplied. Write the cause of death clearly and fully. Physician: please write correct age if especially important. PLEASE WRITE PLAINLY, WITH UNFADING INK.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication, which caused death.)

(A) Arteriosclerotic Heart disease with Cong. Hrt. failure DUE TO Pulmonary Tuberculosis left upper lobe

(B) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Thyroadenoma, rt. lobe Benign Congenital Polycystic disease of Kidneys

INTERVAL BETWEEN ONSET AND DEATH: 1

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 8, 1949 to June 13, 1949 that I last saw the deceased alive on June 12, 1949 and that death occurred at 2 p.m. June 13, 1949 from the cause(s) and on the date stated above.

23A. SIGNATURE R U Rawnsley M. D.

23B. ADDRESS St. Agnes Hosp.

23C. DATE SIGNED 6/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6-16-49

24C. NAME OF CEMETERY OR CREMATORY Good Shepherd

24D. LOCATION (City, town, or county) (State) Ellicott City, Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 14 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS F.C. Higinbothom, Ellicott City, Md.

VS 150

13B

G75299

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E9 81.6 G75299 Registered No.

1. NAME OF DECEASED (Type or Print): George Thomas N-861-4

2. DATE OF DEATH: 6/II/1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

b. Length of stay in Baltimore: 20 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 1517 W. Lexington St. 19-07

5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 25 1901
9. AGE (In years last birthday): 47 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Salem N.J.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Thomas C.R.
14. MOTHER'S MAIDEN NAME: Arlena Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Mry Byrd 506 S. Juniper St. Phila. Pa ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc., but means the disease, injury or complication which caused death.)

(A) Bullet Wound Thorax — DUE TO

(B) — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Restaurant
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 239 N. Gilmor St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 11, 1949 9:10 p. m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐.*

23A. SIGNATURE: Ruth Boyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 12 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/14/1949
24C. NAME OF CEMETERY OR CREMATORY: Mien Cem.
24D. LOCATION (City, town, or county) (State): Darby Pa.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1000 Brantly Ave.

VS 151

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician, please write the cause of death clearly and legibly.

BIRTH NO. 75300

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51 G75300 Registered No.

1. NAME OF DECEASED (Type or Print): Sherman Coniglaud
2. DATE OF DEATH: June 13, 1949
3. PLACE OF DEATH: a. Baltimore City, Maryland. Hal 28
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10 er
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 2 Yrs. 6 Mos. Days
d. STREET ADDRESS (If rural, give location) 805 Greenmount ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	4-12-96	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) N.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Kit Coniglaud
14. MOTHER'S MAIDEN NAME Lillie Fillery
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc., but means the disease, injury or complication which caused death.)
(A) Pulmonary Embolism
DUE TO
(B) Carcinoma of Stomach
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION June 11 1949
19B. MAJOR FINDINGS OF OPERATION Carcinoma of Stomach
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-2- 1949 *to* 6-13- 1949, *that I last saw the deceased alive on* 6-13- 1949, *and that death occurred at* 12:35 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE D. D. Bosley M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED June 13 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 16-49
24C. NAME OF CEMETERY OR CREMATORY Fillery Cem.
24D. LOCATION (City, town, or county) (State) Weldon N. C.

DATE RECEIVED BY LOCAL REGISTRAR JUN 14 1949
REGISTRAR'S SIGNATURE Washington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Elroy O Wilson 1005 Bruntby ave

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. If any item is unknown, please write the word "unknown." Be sure the correct age is especially important. Physicians please write the cause of death clearly and legibly.

46B

G75301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75301

BIRTH NO. G75301

1. NAME OF DECEASED (Type or Print): DAVID BLUM

2. DATE OF DEATH: 6-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3012 Hanlan Ave
C. Length of stay in Baltimore: 57 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-37
D. STREET ADDRESS (If rural, give location): 3012 Hanlan Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 67
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Joseph
14. MOTHER'S MAIDEN NAME: Ida
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Jessie Blum ADDRESS: 3012 Hanlan Ave

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered and the certifier should sign. Physician please write the cause of death clearly and legibly. Correct age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc., but means the disease, injury or complication which caused death.)

(A) Coronary Heart disease about 2 yrs
DUE TO
(B) Hypertensive arteriosclerosis 10-12 yrs
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 3rd 1948 to June-13-1949 that I last saw the deceased alive on June-13-1949, and that death occurred at 3P m., from the causes and on the date stated above.

23A. SIGNATURE: Herman Leidel M.D.
23B. ADDRESS: 2404 Eutaw Pl
23C. DATE SIGNED: 6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-17-49
24C. NAME OF CEMETERY OR CREMATORY: Sherree Tfiloh
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

94a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450.0 G75502 Registered No.

75502 BIRTH NO.

1. NAME OF DECEASED (Type or Print) Hill - Lula

2. DATE OF DEATH 6-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Sq. Hosp.

c. Length of stay in Baltimore 25 years (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 824 N. Parrish 1604

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Widowed	August 10, 93	55	10	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
maid		Virginia	U.S.A.

13. FATHER'S NAME: Authur Cooper

14. MOTHER'S MAIDEN NAME: Martha ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war, or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT, ADDRESS: Katherleen Diggs, 831 N. Fulton Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc., but means the disease, injury or complication which caused death.)

(A) Cardiac tamponade. — DUE TO

(B) Arteriosclerosis of aorta — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 day

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-12, 1949, to 6-13, 1949, *that I last saw the deceased alive on* 6-13, 1949, *and that death occurred at* 4:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE A. J. Lehan M. D.

23B. ADDRESS Franklin Sq. Hosp.

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-16-49	Mt. Auburn	Baltimore 30.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 14 1949	Huntington Williams, M.D.	Wm. A. JACKSON	916 PENNA. AVE.

VS 150

937

Please write plainly, with unfading ink. Every item must be answered. Insert "unknown" if information cannot be obtained. Physician: please write the cause of death clearly and legibly. Be correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75303

BIRTH NO. 75403

1. NAME OF DECEASED (Type or Print) Anna Jones (Annie Jones)

2. DATE OF DEATH June 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 909 Whatcoat Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 40 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 909 Whatcoat Street

5. SEX Female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH ? 1876 | 9. AGE (In years last birthday) 72 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Annie Williams ADDRESS 530N. Gilmore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc., it means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE (Violence) PRIMARY ☐ OR CONTRIBUTORY ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE George G. Merrill M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED June 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 6-14-49 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR JUN 14 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS Wm A. Jackson - 916 Penna. Ave.

VS 151

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75504

1. NAME OF DECEASED (Type or Print) — William A. Butz — 2. DATE OF DEATH — June 13. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — 106 E Randall
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Left Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE — 106 E Randall
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Balto
d. STREET ADDRESS (If rural, give location) — 106 E. Randall 24-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	May 30 1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — Carpenter
10B. KIND OF BUSINESS OR INDUSTRY — Camp Meade
11. BIRTHPLACE (State or foreign country) — Balto
12. CITIZEN OF WHAT COUNTRY? — U.S
13. FATHER'S NAME — George J Butz
14. MOTHER'S MAIDEN NAME — Mary J. Elliott
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) — No
16. SOCIAL SECURITY NO.
17. INFORMANT — Mrs Florence S Mayston — ADDRESS 106 E Randall

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.) (A) Coronary Occlusion.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B) Hypertensive Cardio Vascular Disease — 10-15 yr
DUE TO (C) Portal Cirrhosis. — 10-15 yr
Ascites

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1946, 19__, to June 13th, 1949, that I last saw the deceased alive on June 13, 1949, and that death occurred at 9.30 A.M., from the causes and on the date stated above.

23A. SIGNATURE — M. D. — 23B. ADDRESS 642 N. Eut. Blvd — 23C. DATE SIGNED 6-14-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 16	Glen Haven	Anne Arundel Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: J. Harold Ellis 1411 Eutaw St Baltimore

VS 150

124B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. In case death is especially important. Physician: please write the cause of death clearly and legibly.

G75305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

G75305 Registered No.

STATE FILE NO.

1. NAME OF DECEASED (Type or Print) George Wallace

2. DATE OF DEATH June 13th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1317 Madison Avenue

C. Length of stay in Baltimore: Yrs. Unknown Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-08
D. STREET ADDRESS (If rural, give location) 2324 McCulloh Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	C	Married	Nov. 21, 1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Amelia County, Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Wallace

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give wars or dates of service) no

16. SOCIAL SECURITY NO. 212-18-7079

17. INFORMANT Mrs. Williams - ADDRESS 1317 Madison Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension - Cardio — DUE TO

(B) Vascular Renal-Disease 1-2 yrs. — DUE TO

(C) —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 12, 1949, *to* June 11, 1949, *that I last saw the deceased alive on* June 11, 1949, *and that death occurred at* 1:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D. Robert L. Jackson

23B. ADDRESS 600 N. Arlington Ave.

23C. DATE SIGNED 6-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6/15/49

24C. NAME OF CEMETERY OR CREMATORY Arbutus Cemetery

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 14 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR William J. Chatman Jr.

ADDRESS 1701 Mc Culloh St. Balto. Md.

VS 150

1310

G25306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

60 ✓

Registered No. G25306

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Reid, Katie

2. DATE OF DEATH 6-12-49

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTO., MD.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 632 S. Paca St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 632 S Paca St. 22 02 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col	Married	3/11/1899	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) West Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) n/o

16. SOCIAL SECURITY NO.

17. INFORMANT Edgar D. Reid ADDRESS 632 S. Paca St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Recurrent bilateral nephro-lithiasis.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION April 29 49

19B. MAJOR FINDINGS OF OPERATION Staghorn calculus R.

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Hospitalized and seen ~~Apr~~, *that I last saw the deceased alive on* June 1 19 49, *and that death occurred at* 9:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M.D. R. D.

23B. ADDRESS University Hospital

23C. DATE SIGNED 6/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) 24B. DATE 6/15/49

24C. NAME OF CEMETERY OR CREMATORY Mt Auburn

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY REGISTRAR JUN 14 1949

REGISTRAR'S SIGNATURE [illegible]

25. FUNERAL DIRECTOR ADDRESS Joseph A. Lively, 661 W. Barre St

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct as age is especially important. Physician: please write the cause of death clearly and legibly.

134a

G75807 129602

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75807
Registered No.

1. NAME OF DECEASED (Type or Print) William Somogyi

2. DATE OF DEATH 6-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Woodlawn
D. STREET ADDRESS (If rural, give location) 107 Woodlawn Ave. Z 20

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	May 28- 1949			14		

10A. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Steve Somogyi
14. MOTHER'S MAIDEN NAME Julia Zochok

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT B.C.H. Records ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hydrocephalus
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6- 12- , 1949, *to* 6- 12- , 1949, *that I last saw the deceased alive on* 6- 12- 1949, *and that death occurred at* 10.45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE R. L. Rogers M.D.
23B. ADDRESS B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED 6-12-1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/14/49
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State) Eastern Blvd., Balto Co.

DATE RECEIVED BY LOCAL REGISTRAR JUN 14 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR Roland F. Fisher
ADDRESS Dundalk, Md.

VS 150

157a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1 G75508 Registered No.

1. NAME OF DECEASED (Type or Print) WALT[illegible]R STEWARD SALISBURY

2. DATE OF DEATH June 12,1949

3. PLACE OF DEATH:
A. Baltimore City, Mary[illegible]

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Mar[illegible]e Hospital Wyman Pk. Dri[illegible] & 31st St.

c. Length of stay in Balt[illegible]re ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2819 Alvarado Square 27-07

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 11/15/94
9. AGE (In years last birthday) 54 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10B. KIND OF BUSINESS OR INDUSTRY Policeman

11. BIRTHPLACE (State or foreign country) Balto, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles S. Sa[illegible]sbury
14. MOTHER'S MAIDEN NAME Rose Harrigan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) W I
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Records- US Marine Hospital, Balto, Md. ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Myocardial infarction	16 hrs.
	DUE TO (B)	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Duodenal ulcer, old	8 hrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 12, 1949, *to* June 12, 1949 *that I last saw the deceased alive on* June 12, 1949 *and that death occurred at* 4:10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE John L. Wilson M. D. John L. Wilson
23B. ADDRESS US Marine Hospital, Balto, Md.
23C. DATE SIGNED 6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried
24B. DATE 6/16/49
24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 14 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Leonard J. Cluck ADDRESS 5305 Harford Rd

VS 150

94a

G75209 M. 1[illegible]690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75209

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Walter Henry

2. DATE OF DEATH 6- 11- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 14 W. Lee ST. 32-01

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Feb. 6 1889
9. AGE (In years last birthday) 60 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Williams
14. MOTHER'S MAIDEN NAME Marie Forbes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Records B.C.H. 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
Wm. H. Kammer, M.D.
Per G. C. Merrill M. D.
CHIEF OR ASST. MEDICAL EXAMINER

INTERVAL BETWEEN ONSET AND DEATH: 5 HRS.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6- 11- , 19 49 *to* 6- 11- , 1949, *that I last saw the deceased alive on* 6- 11- , 19 49 *and that death occurred at* 10/20P m., *from the causes and on the date stated above.*

23A. SIGNATURE A. J. Rogers M. D.
23B. ADDRESS B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED 6-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6- 16-49
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State) Brooklyn MD

DATE RECEIVED BY LOCAL REGISTRAR JUN 1[illegible]
REGISTRAR'S SIGNATURE Twittington Williams, MD
25. FUNERAL DIRECTOR Elroy O. Wilson
ADDRESS 1000 Brantly

VS 150

To be approved by the Chief Medical Examiner. 94a and

G75310

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 1 Registered No. G75310

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ONA KAMANSKY - (GAVENAITE)

2. DATE OF DEATH 6-12-9

3. PLACE OF DEATH
A. Baltimore City, Maryland 20 PARKIN ST.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) None.
c. Length of stay in Baltimore - 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 20 PARKIN ST 18-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F.	W.	WIDOW	July 20 1886	63	10	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TAILOR.	TAILORING	LITHUANIA	U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No No	

17. INFORMANT William J. KAMANSKY. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 1 HOUR

DUE TO (B) CORONARY ARTERIOSCLEROSIS

DUE TO (C) CARDIO-VASCULAR DISEASE — 7 YEARS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO ARTERIOSCLEROSIS

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 30 APRIL, 1949 to 12 JUNE, 1949 that I last saw the deceased alive on 12 JUNE, 1949 and that death occurred at 11:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward Mulan M. D.	682 WASHINGTON BLVD	13 JUNE 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	6-15-49	HOLY REDEEMER	BALTIMORE, MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 14 1949	Huntington Williams, M.D.	S. Speharnias	703 McHenry St.

VS 150

Every death is a mystery, with unknown and unknowable ink. Every death is a mystery, with unknown and unknowable ink. Every death is a mystery, with unknown and unknowable ink.

G75311

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

413 Registered No. G75311

1. NAME OF DECEASED (Type or Print) Agnes Brooks

2. DATE OF DEATH 6-11-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland B. Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1313 E. Eager St

c. Length of stay in Baltimore: 6 yrs Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1313 E. Eager St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col.	Single	6-15-1883	66 67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Non

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME Arthur Brooks

14. MOTHER'S MAIDEN NAME Frances ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Laura Northern ADDRESS 1313 E. Eager St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		INTERVAL BETWEEN ONSET AND DEATH
(A)	Congestive Heart Failure	2 wks
DUE TO (B)	Hypertensive Cardiovascular Disease	?
DUE TO (C)	Arteriosclerosis	?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 1949 *to* June 10, 1949, *that I last saw the deceased alive on* 6-10, 1949 *and that death occurred at* 6 3/4 *m., from the causes and on the date stated above.*

23A. SIGNATURE Leon Young M. D. 23B. ADDRESS 1113 N. Caroline Street 23C. DATE SIGNED 6-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 6-14-49 24C. NAME OF CEMETERY OR CREMATORY St Mary Cem 24D. LOCATION (City, town, or county) (State) Alexandria Va

DATE RECEIVED BY LOCAL REGISTRAR JUN 14 1949 REGISTRAR'S SIGNATURE Carrington Williams 25. FUNERAL DIRECTOR Raynes Sanders ADDRESS 1412 E. Preston St 9-2-49

VS 150

Please write in information asked for clearly. Be sure to state the cause of death clearly and correct age is especially important. Physician: please write legibly.

G75312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75312

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SUSIE TULL CATLIN

2. DATE OF DEATH: June 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 425 Westgate Road

c. Length of stay in Baltimore: 1½ yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 425 Westgate Road 28 04

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept. 14, 1861
9. AGE (In years last birthday): 87 yrs. (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Greenbackville, Va.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: - Pope
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. John Stokes
ADDRESS: 425 Westgate Rd.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean mode of dying, e.g., heart failure, asthenia. It means the disease, injury or complication which caused death.)

(A) Myocardial Decompensation — Interval between onset and death: 3 Mo.

DUE TO

(B) Generalized Arteriosclerosis — 5 Yr.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 11-8, 1948 *to* 6-14, 1949 *that I last saw the deceased alive on* 6-14, 1949, *and that death occurred at* 7:50 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Melvin R. Gallagher M.D.
23B. ADDRESS: Cotonsville 6-28, Md
23C. DATE SIGNED: 6-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/17/49
24C. NAME OF CEMETERY OR CREMATORY: Sunny Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Crisfield, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: BRADSHAW FUNERAL HOME
ADDRESS: Crisfield, Md.

VS 150

937

G75313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$5.00

G75313

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jessie B. Slack

2. DATE OF DEATH June 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 3014 Guilford Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) none

c. Length of stay in Baltimore 86 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3014 Guilford Ave. 12-02

5. SEX female

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single

8. DATE OF BIRTH Dec. 6, 1861

9. AGE (In years last birthday) 87

If Under 1 Year: Months Days

If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Texas

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Jacob Slack

14. MOTHER'S MAIDEN NAME Llewlyn Gilliland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Miss Edith B. Beasely ADDRESS 3014 Guilford Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

(B) Arteriosclerosis — Unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from June 1, 1949 to June 12, 1949, that I last saw the deceased alive on June 12, 1949, and that death occurred at 1000 m., from the causes and on the date stated above.*

23A. SIGNATURE Charles K. Goodbrow, M.D.

23B. ADDRESS 2923 St Paul St.

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6/15/49

24C. NAME OF CEMETERY OR CREMATORY Loudon Park

24D. LOCATION (City, town, or county) (State) Frederick Ave.

DATE RECEIVED BY LOCAL REGISTRAR JUN 14 1949

REGISTRAR'S SIGNATURE Thurlington Williams M.D. John O Mitchell 1900 Eutaw Pl.

25. FUNERAL DIRECTOR J.O.Mitchell & Sons

ADDRESS 1900 Eutaw Place

VS 150

97

Please write in ink, with typewriter if available. Be sure information shown on certificate is entirely and correct. Write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please

G75314

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75314

1. NAME OF DECEASED (Type or Print) (Sarah) Hadie Churchill

2. DATE OF DEATH June 14 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1603 E. Madison St 705

5. SEX F | 6. COLOR OR RACE Col. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH Sept 12, 1879 | 9. AGE (In years last birthday) 69 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles E. Henry

14. MOTHER'S MAIDEN NAME Laura ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT Carrie Henry | ADDRESS 1603 E Madison St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic P.V. Disease

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Emil L Rogers M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED 12 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE June 15/49 | 24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem | 24D. LOCATION (City, town, county) (State) A.A. County Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 14 1949 | REGISTRAR'S SIGNATURE Washington Williams, MD | 25. FUNERAL DIRECTOR Mrs Robt A. Elliott & Dgt | ADDRESS 1129 N. Carrollton

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied; correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75315

BIRTH NO. 75315,

1. NAME OF DECEASED (Type or Print) Mamie Davis

2. DATE OF DEATH 6/13/49

3. PLACE OF DEATH: X Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md 16 03
D. STREET ADDRESS (If rural, give location) 909 N. Fulton Ave

6. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 909 N. Fulton Ave

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C.	Married	Oct. 15, 1888	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Edgefield S.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Phillip Mithis

14. MOTHER'S MAIDEN NAME Lydia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT C.A. Davis ADDRESS 909 N Fulton Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic Cardiovascular Disease	
ANTECEDENT CAUSES	DUE TO (B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE D. P. Pinkerton M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED 6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-16-49	Arbutus Memorial Pk	Arbutus Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 14 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR Mrs Kate R. Williams ADDRESS 322-93[illegible]

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. In the case of death clearly and forcibly. Physician: please write the cause of death clearly and forcibly. Physician: please write the cause of death clearly and forcibly. Physician: please write the cause

675316

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

150

675316 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GRINATH, CHARLES

2. DATE OF DEATH JUNE 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland SINAI HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4719 Delaware Ave 27-16

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	M.	Jan 1, 1888	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Man
10B. KIND OF BUSINESS OR INDUSTRY Bay Bath Dept.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles O. L. Grinath.
14. MOTHER'S MAIDEN NAME Anna E. Hauser
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
16. SOCIAL SECURITY NO. 215-03-0765
17. INFORMANT Mrs. Anna E. Grinath ADDRESS 4719 Delaware Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardio-vascular disease Emaciation
DUE TO
(B) Carcinoma of the esophagus with metastasis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION Carcinoma of the esophagus with infiltration to the trachea
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23A. SIGNATURE Hosea Van L. Lacson M.D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED June 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/15/49
24C. NAME OF CEMETERY OR CREMATORY Meadowridge
24D. LOCATION (City, Town, or County) (State) Elkridge Balto Co.

DATE RECEIVED BY LOCAL REGISTRAR JUN 14 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Loring Byers
ADDRESS 5025 Pk Heights Ave.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item is important. Physician please write the cause of death clearly and legibly. Be correct age is especially important.

46a

Lawrence CERTIFICATE CORRECTED 6-20-49

G75317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4th 1

Registered No. G75317

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSHUA ~~JOHN~~ LAWRENCE NORRIS

2. DATE OF DEATH: 6/17/49.

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 27-16
D. STREET ADDRESS (If rural, give location): #704 Delaware Ave, #15.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	5/2/1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector

10B. KIND OF BUSINESS OR INDUSTRY: Plumbing

11. BIRTHPLACE (State or foreign country): Balto.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Norris

14. MOTHER'S MAIDEN NAME: Mal Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Same ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Abt Weeks

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/7, 1949 *to* 6/14, 1949 *that I last saw the deceased alive on* 6/14, 1949, *and that death occurred at* 12:10A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert E. Ensor M. D.	Mercy Hospital	6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/17/49	London Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 14 1949	Evelyn Williams, M.D.	Loring Byers	5005 Park Heights Ave

Vs 158 1949

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if known. If unknown or not applicable, write the word "unknown" or the abbreviation "N. A." Be sure to state the cause of death clearly and legibly. Physician: please write the cause of death in terms which convey definite information as to the underlying pathology. Indefinite or unusual terms should be avoided. Exact age is especially important.

CERTIFICATE CORRECTED 6-22-49 ✓

G75318 — BALTIMORE CITY HEALTH DEPARTMENT — 416 — G75318

CERTIFICATE OF DEATH — Registered No.

CERTIFICATE CORRECTED 6-27-49

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elsie I. Armstrong

2. DATE OF DEATH: June 13, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland general Hospital
c. Length of stay in Baltimore (3 years)? 30 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE
b. COUNTY
3215 W Garrison Ave 5 27-18
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
d. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	married	11-17 (90) 1840	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housefurke	no	Pennsylvania	America

13. FATHER'S NAME: George L Maice
14. MOTHER'S MAIDEN NAME: Lou Babcock (Maice Stead)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT	ADDRESS
No			Husband	as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Heart block — INTERVAL BETWEEN ONSET AND DEATH: 2-3 hrs
DUE TO
(B) R heumatic heart disease C congestive failure — unknown duration 24 yrs
DUE TO
(C) Hypertensive cardiovascular renal disease — 10 yrs
Generalized Edema — 2-3 yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 6-13, 1949 to 6-13, 1949 that I last saw the deceased alive on 6-13, 1949, and that death occurred at 4:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marguerite Louise Cadle, M.D.	Md. General Hosp.	6/13

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/16/49	Woodlawn	Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 14 1949	Huntington Williams, M.D.	Loring Byers	5005 Pk Heights Ave.

VS 150

1310

G75319

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. G75319 Registered No.

1. NAME OF DECEASED (Type or Print) Edna De Paula

2. DATE OF DEATH 6/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp.
c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-13
D. STREET ADDRESS (If rural, give location) 4661 Park Heights Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
F	W	Widow	Sept 30/1895	53				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Bryant Crauss
14. MOTHER'S MAIDEN NAME Margaret Barbor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B) Arteriosclerosis CV disease
DUE TO
(C) Diabetes Mellitus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/10 19 49 to 6/11 19 49, that I last saw the deceased alive on 6/11 19 49, and that death occurred at 2:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE Joseph L. Oppenheimer M.D.
23B. ADDRESS Mercy Hosp.
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/15/49
24C. NAME OF CEMETERY OR CREMATORY Cathedral
24D. LOCATION (City, town, or county) (State) Balto City Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 14 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Loring Byrn
ADDRESS 5005 Park Heights Ave

VS 150

61

G75320

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75320

1. NAME OF DECEASED (Type or Print): EVA WALTER

2. DATE OF DEATH: June 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6 S. Monroe St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6 S. Monroe St. 20-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	Oct. 1, 1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Kreiser
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Philip Walter — ADDRESS: 6 S. Monroe St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Cerebral Arteriosclerosis. ?

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23A. SIGNATURE: Samuel E. Bogard M. D.
23B. ADDRESS: 1905 W. Baltimore St.
23C. DATE SIGNED: 6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-15-49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUN 14 1949
REGISTRAR'S SIGNATURE: [illegible] Baltimore, Md.
25. FUNERAL DIRECTOR: Benja A. Insley
ADDRESS: Baltimore - Fayette St.

VS 150

93D1

G75521 ✓ X 289.0 G75521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Emory Douglas Brinson

2. DATE OF DEATH: June 14 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Harriet Lane

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Florida B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clearwater

D. STREET ADDRESS (If rural, give location): Lake View Dr.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	White		3-13-46	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Florida

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Emory Brinson

14. MOTHER'S MAIDEN NAME: Evelyn Case

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be completed. Report of investigation should be typewritten. Write the cause of death clearly and legibly. Correct age is especially important. Physician: please write the

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.)

(A) Hepatic failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) ? Gaucher's Disease (splenic anemia)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/5 1949 *to* 6/14 1949, *that I last saw the deceased alive on* 6/14 1949, *and that death occurred at* 11:50 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Bryan M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 15, 1949	Clearwater Cem	Clearwater - Florida

DATE RECEIVED BY LOCAL REGISTRAR: JUN 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wood Funeral Home ADDRESS: Gilmore St.

VS-150

75a

G753222

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No. G753222

1. NAME OF DECEASED (Type or Print): Minnie Elizabeth Paul

2. DATE OF DEATH: June 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR ~~INSTITUTION~~: St. Joseph's (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: app. 70 yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
b. STREET ADDRESS (If rural, give location): 901 S. Highland Ave. 2609

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar. 8, 1870
9. AGE (In years last birthday): 79 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Gewig
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Andrew Paul ADDRESS: 537 N. Highland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pyelonephritis

DUE TO

(B) Arterio-sclerotic Hypertension Cardio-vascular Disease

DUE TO

(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 7, 1949 *to* June 12, 1949, *that I last saw the deceased alive on* June 12, 1949 *and that death occurred at* 8:15a *m., from the causes and on the date stated above.*

23A. SIGNATURE: Karl E. Peters, Jr. M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: June 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/15/49
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cem.
24D. LOCATION (City, town, or county) (State): German Hill Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 2601-3-5 E. Madison St.

VS 150

93D

G75323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 17

Registered No. G75323

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Anna Haberman - Tomsik

2. DATE OF DEATH June 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hosp.
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 401 N. Milton Avenue 6-6-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	July 8, 1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Czechoslovakia	

13. FATHER'S NAME Taluzek

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Frank J. Tomsik - 401 N. Milton Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Generalized Carcinomatoses	
ANTECEDENT CAUSES	DUE TO (B) Cystadenocarcinoma ovary	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Arteriosclerotic - Hypertensive H.D.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
April 14 1949	Generalized Carcinoma from ovary	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 9 1949, to June 12, 1949 *that I last saw the deceased alive on* June 12, 1949, *and that death occurred at* 5:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. J. Mahler M. D.	Bon Secours Hosp.	6/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/15/49	Holy Redeemer Cem.	4430 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 14 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

49a

Please write in ink. Every item must be answered, with UNKNOWN if not known. Physician: please write the cause of death clearly and legibly. Be especially important.

G75324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75324 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Kalman Dworkin

2. DATE OF DEATH JUN 14 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore — Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE D.C. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Washington N.W.

D. STREET ADDRESS (If rural, give location) 5016 Third St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	? ? 70	79		

10A. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired Rabbi

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Solomon Dworkin

14. MOTHER'S MAIDEN NAME Dina ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, with unfading ink. Report only one cause of death clearly and legibly. Do not enter the mode of dying, such as heart failure, asphyxia, anemia, or uremia. Do not enter merely the name of an organ or tissue. Do not enter indefinite terms such as cancer, senility, or tuberculosis. Be sure to state the cause of death clearly and legibly. Correct age is especially important. Physician, please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Stomach — INTERVAL BETWEEN ONSET AND DEATH: 2-3 Mos

DUE TO

(B) Heart Failure — 1 day

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 13 June 49

19B. MAJOR FINDINGS OF OPERATION Carcinoma Stomach

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-6 1949 *to* 6-14 1949, *that I last saw the deceased alive on* 6-14 1949 *and that death occurred at* 920 *m., from the causes and on the date stated above.*

23A. SIGNATURE Jacob C. Hirschhorn M.D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED 14 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6-15-49

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State) Washington DC

DATE RECEIVED BY LOCAL REGISTRAR JUN 15 1949

REGISTRAR'S SIGNATURE Tennyson Williams M.D.

25. FUNERAL DIRECTOR Jack Lewis Inc

ADDRESS 2100 Eutaw Pl

VS 150

46B

G75325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53 G25325 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. MARIE J. DAVIDSON

2. DATE OF DEATH: 6-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

C. Length of stay in Baltimore: 45 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-37
D. STREET ADDRESS (If rural, give location): 3314 Dyonne Falls Pkwy

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept 10-1903
9. AGE (In years last birthday): 45
If Under 1 Year: Months / Days
If Under 1 Day: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John B. Bannon

14. MOTHER'S MAIDEN NAME: Mary E. Smith.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT / ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinosis

DUE TO

(B) Carcinoma of Sigmoid

(C) c Metastasis to Liver.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 4-22-49
19B. MAJOR FINDINGS OF OPERATION: Ca. of Sigmoid c Metastasis
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* —, 19—, *to* 6-12, 1949, *that I last saw the deceased alive on* 6-12, 1949, *and that death occurred at* 8:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: F. C. Rodriguez M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 6-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): June
24B. DATE: 15/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Harry H. Witzke
ADDRESS: 4101 Edmondson Ave

VS 150

Rodriguez

46E

G75526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58-10

G75526

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Thomas J. Connelly Sr.

2. DATE OF DEATH 6/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1807 Enson St

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.

D. STREET ADDRESS (If rural, give location) 1807 Enson St. 9-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	10/10/1871	77	8	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Blacksmith	Balto. Transit Co	Dublin Ireland	

13. FATHER'S NAME: Thomas J. Connelly

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Thos. J. Connelly Jr.	2049 Kennedy Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerrhosis of Liver

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 20, 1949 *to* June 12, 1949 *that I last saw the deceased alive on* June 11, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph Toohey M.D.	444 S. Ellwood Ave	June 14, 49

24A. BURIAL / CREMATION / REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/15/49	Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 15 1949	Huntington Williams, MD	Wm Cook Inc	1217 St. Paul St.

VS 150

1248

G75327

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 49-11596

CERTIFICATE OF DEATH

5-93

Registered No. G75327

1. NAME OF DECEASED (Type or Print): Baby Girl Peaco

2. DATE OF DEATH: June 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital
C. Length of stay in Baltimore: 25 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1515 East Preston Street

8-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	S	June 5, 1949			12 / 10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Veronica Logan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Veronica Peaco — ADDRESS: 1515 E. Preston Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) anoxia
DUE TO
(B) ? congenital anomalies ?
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: congenital ascites

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [✓] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 5, 1949 *to* June 5, 1949 *that I last saw the deceased alive on* June 5, 1949, *and that death occurred at* 9:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Glen G. Rice, M. D.
23B. ADDRESS: 601 North Broadway
23C. DATE SIGNED: 6-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JUN 7 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR — ADDRESS:

VS 150

157M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if known. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75328 G75328

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
177 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George Jensen Sisson
2. DATE OF DEATH 6/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1823 N. Port st.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1823 N. Port st 8-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	July 11 1872	76	11 7	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10B. KIND OF BUSINESS OR INDUSTRY Building
11. BIRTHPLACE (State or foreign country) Warsaw Va
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Louis H. Sisson
14. MOTHER'S MAIDEN NAME Willie Ann Webb
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-01-9803
17. INFORMANT Richard Askins 5311 ADDRESS Ready Ave

MEDICAL CERTIFICATION

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Carcinoma of Prostate
DUE TO with Metastasis
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from May 25 1949 to June 14 1949, that I last saw the deceased alive on June 14 1949, and that death occurred at 11:45 a. m., from the causes and on the date stated above.

SIGNATURE Simon L. Worden M. D.
23B. ADDRESS 2900 Alameda
23C. DATE SIGNED 6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/15/49
24C. NAME OF CEMETERY OR CREMATORY Christian Church
24D. LOCATION (City, town, or county) (State) Fork Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 15 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Wm Cook Inc. 217 St. Paul st.

VS 150

5/B

Write the cause of death clearly and legibly. Physician please write exact age is especially important.

G75329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

475 Registered No. G75329

BIRTH NO. B.C. 49-06735

1. NAME OF DECEASED (Type or Print) GEORGE T. JOHNSON

2. DATE OF DEATH June 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2029 Llewellyn Ave. 8-07

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 3-31-49
9. AGE (In years last birthday) — If Under 1 Year: Months 3, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Alfred Johnson

14. MOTHER'S MAIDEN NAME: Evelyn Goode

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Evelyn Goode — ADDRESS: 2029 Llewellyn Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Upper respiratory infection
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED June 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE 6-15-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 15 1949
REGISTRAR'S SIGNATURE: Curtis for Williams, M.D.
25. FUNERAL DIRECTOR: Chas O. Wilson
ADDRESS: Brooklyn Md

VS 151

104a

G75330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0 1 0

Registered No. G75330

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALMA MARIE HAMLIN

2. DATE OF DEATH June 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital
Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 708 Edmondson Ave. 17-03

5. SEX F
6. COLOR OR RACE Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 3/4/08
9. AGE (In years last birthday) 41 40
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant
10B. KIND OF BUSINESS OR INDUSTRY US Marine Hospital Balto, Md.
11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Philip Crocket
14. MOTHER'S MAIDEN NAME Carrie Colbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Records- US Marine Hospital, Balto, Md. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Miliary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 5 mos.

DUE TO

(B) Tuberculous meningitis — 5 mos.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 16, 1949 *to* June 13, 1949 *that I last saw the deceased alive on* June 13, 1949 *and that death occurred at* 1:50A m., *from the causes and on the date stated above.*

23A. SIGNATURE John L. Wilson
John L. Wilson M. D.
23B. ADDRESS US Marine Hospital, Balto, Md.
23C. DATE SIGNED 6/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 15-49
24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem.
24D. LOCATION (City, town, or county) (State) Arbutus Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 15 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Choyce. Wilson
ADDRESS 1008 Brantley Rd

VS 150

13B

Please write the cause of death clearly and correct age is especially important. Physicians:

G75531

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75531

1. NAME OF DECEASED (Type or Print) Jacob Zinz

2. DATE OF DEATH June 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hosp.tal
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1728 Ruxton Ave 15-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	WIDOWED	1891	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Baltimore Md	

13. FATHER'S NAME: Simon Zinz

14. MOTHER'S MAIDEN NAME: Onkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Boris Zinz ADDRESS: 1728 Ruxton Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Overwhelming ghchalized infection — DUE TO

(B) Diabetes Mellitus — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-27, 1949, *to* 6-14, 1949, *that I last saw the deceased alive on* 6-14, 1949 *and that death occurred at* 6:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Katherine V. Krug, M. D.	West Baltimore General Hospital	6-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 15/49	Hebrew Washington Rd	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 15 1949	Huntington Williams, M.D.	Sol Levinson & Bros	1126 W North Ave

VS 150

61

G75532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

334 Registered No. G75532

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY COHEN

2. DATE OF DEATH 6-15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4530 Pimlico Road

C. Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4530 Pimlico Road

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 67 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Hellel

14. MOTHER'S MAIDEN NAME Tobe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT Sara Cohen 4530 Pimlico Road ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Arteriosclerosis — Interval between onset and death: 8 yrs.
DUE TO
(B)
DUE TO
(C) Pernicious Anemia — 16 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION None | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 12, 1949 *to* June 15, 1949, *that I last saw the deceased alive on* June 14, 1949, *and that death occurred at* 2:20 PM. *from the causes and on the date stated above.*

23A. SIGNATURE Milton Bernstein M.D. M. D. | 23B. ADDRESS 5801 Holben Road | 23C. DATE SIGNED 6/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 6-15-49 | 24C. NAME OF CEMETERY OR CREMATORY Beth Israel | 24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 15 1949 | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

VS 150

73a

G75333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

517

Registered No. G75333

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Oscar I. Dubow

2. DATE OF DEATH 6-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore general Hospital

c. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2851 Cold Spring Lane 15-13

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 53 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman

10B. KIND OF BUSINESS OR INDUSTRY Foreman - Tailor Shop

11. BIRTHPLACE (State or foreign country) Rah

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Max

14. MOTHER'S MAIDEN NAME Freeda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) World War I

16. SOCIAL SECURITY NO. 212-09-6903

17. INFORMANT Belle Dubow ADDRESS 2851 Coldspring Lane

MEDICAL CERTIFICATION

(Correct age is especially important. Physicians: please write the cause of death clearly and forcibly.)

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) laryngospasm	45 min.
	DUE TO NEUROSIS	
ANTECEDENT CAUSES	(B) Probable psinogenic etiology	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) a.m. p.m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6:30 PM 6-13, 1949, *to* 11:30 PM 6-13, 1949, *that I last saw the deceased alive on* 6-13, 1949, *and that death occurred at* 11:30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE Katharine V. Kisner M. D. | 23B. ADDRESS West Baltimore General Hosp | 23C. DATE SIGNED 6-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 6-15-49 | 24C. NAME OF CEMETERY OR CREMATORY Mt Carmel | 24D. LOCATION (City, town, or county) (State) Germany Hill Rd Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 15 1949 | REGISTRAR'S SIGNATURE Twitington Williams MD | 25. FUNERAL DIRECTOR Jack Levin Inc - ADDRESS 2100 Eutaw Pl

VS 150

105.

G75334

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75334

1. NAME OF DECEASED (Type or Print): Ida Goodman

2. DATE OF DEATH: June 15/ 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2476 Shirley Avenue
C. Length of stay in Baltimore: 44 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2527 Quantico Avenue 15-13

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1881
9. AGE (In years last birthday): 68
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hirsh Fogel
14. MOTHER'S MAIDEN NAME: Minnie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Bennie Goodman ADDRESS 3916 Reisterstown Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Nose
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 25, 19[illegible], *to* June 15, 1949, *that I last saw the deceased alive on* June 15, 1949, *and that death occurred at* 2 1 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Manuel Levin, M. D.
23B. ADDRESS: 4818 Reisterstown Rd
23C. DATE SIGNED: June 15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/15/49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt. Carmel
24D. LOCATION (City, town or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JUN 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: S. Levinson & Bros 1124 W North Ave

VS 150

53

Please write the cause of death clearly and legibly. Physician, please write the correct age is especially important.

G75335

BIRTH NO B.C. 49-11897

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

7 6 G75335 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Evans

2. DATE OF DEATH: June 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Mercy Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: 2 1/2 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: newborn. (Mercy Hosp)
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location): 1006 Dartmouth Rd x7-48

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	White	Single	June 12, 1949			2 1/2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles F. Evans.
14. MOTHER'S MAIDEN NAME: Frances St. Leger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (mother) ADDRESS: Mrs. Frances Evans. 1006 Dartmouth

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Prematurity

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 12, 1949 *to* June 14, 1949, *that I last saw the deceased alive on* June 14, 1949, *and that death occurred at* 5:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph F. LiRia M. D.
23B. ADDRESS: Mercy Hosp.
23C. DATE SIGNED: 6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 6/15/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas F. Evans & Son
ADDRESS: 118 W. Mt. Royal Av. 159

VS 150

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G75536 — BALTIMORE CITY HEALTH DEPARTMENT — 0 08 — G75536

BIRTH NO. — **CERTIFICATE OF DEATH** — Registered No.

1. NAME OF DECEASED (Type or Print): Mary Smith Lawson

2. DATE OF DEATH: 6-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 634 Cheraton Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 25-3
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Cherry Hill-25
D. STREET ADDRESS (If rural, give location): 637 Cheraton Road.

c. Length of stay in Baltimore: 24 yrs. (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Negro.	Married	12-5-24	24 yr.	5	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None.	None	Baltimore, Md.	U. S.

13. FATHER'S NAME: Harrison Evans

14. MOTHER'S MAIDEN NAME: Clara Copper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-28-0283

17. INFORMANT: Helen Richardson — ADDRESS: 634 Cheraton Rd

MEDICAL CERTIFICATION — Please write the cause of death clearly and correct age is especially important. Physician:

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days.
DUE TO
(B) Koch's Infection — 2 mo
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 16, 1949, *to* June 14, 1949, *that I last saw the deceased alive on* June 13, 1949, *and that death occurred at* 7:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leroy G. Frack, M. D. — 23B. ADDRESS: 303 Bridgeview Road — 23C. DATE SIGNED: 6-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 6/18/49 — 24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem. — 24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 15 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Metropolitan Funeral Homes — ADDRESS

VS 150

13c

G75337 ✓ E850 G75337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. BC. H-94813 Registered No.

1. NAME OF DECEASED (Type or Print) Earline Spotts Wood — N-166-0 — 2. DATE OF DEATH 6/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lyden ham. Hosp.tal

c. Length of stay in Baltimore 18 mos — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balt. more- Md.
D. STREET ADDRESS (Rural, give location) 630 Baker St 15-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	Col	Single.	Nov. 16-1947	1yr6mos		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant		Balt.imore- Md.	

13. FATHER'S NAME: Earl Spotts Wood

14. MOTHER'S MAIDEN NAME: Katherine Burton ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			-Mother-	

MEDICAL CERTIFICATION — Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lead intoxication — INTERVAL BETWEEN ONSET AND DEATH: 4 days?

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chicken-Pox

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATIONS	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/12, 1949, *to* 6/13, 1949, *that I last saw the deceased alive on* 6/13, 1949, *and that death occurred at* 1:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lar. Cohen M.D.	Lydenham. Hosp.	6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 16-49	Mt. Calvary	Balto Md

DATE RECEIVED BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 15 1949	Washington Williams, M.D.	Wm Brookes	1463 N. Carey St

VS. 150

780

G75538

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75538

1. NAME OF DECEASED (Type or Print) Burleigh Stedman

2. DATE OF DEATH 6/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lyden Lan Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Catonsville-
D. STREET ADDRESS (If rural, give location) 7-Wyadenest-Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	W		Nov. 21-1943	6 Yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF (WHAT COUNTRY?)
School		Baltimore- Md.	U.S.A.

13. FATHER'S NAME Henry Stedman

14. MOTHER'S MAIDEN NAME Rovanna Burleigh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mother-	Catonsville- Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Post Meningo Encephalitis — INTERVAL BETWEEN ONSET AND DEATH: 3 mos

DUE TO

(B) Meningo

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
3/4/49	Tracheotomy	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/5 *,* 19 49 *to* 6/13 *,* 19 49 *that I last saw the deceased alive on* 6/13 *,* 19 49 *and that death occurred at* 7:30 *m.; from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lee Cohen M. D.	Lyden Lan Hosp.	6/13

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 16/49	Loudon Park	3800 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 15 1949	Huntington Williams, M.D.	John D. Mitchell & Sons	1900 Eastern Ave

VS 150

35

Complete the cause of death clearly and legibly. Physician: please write the exact age is especially important.

E841 G75339

G75339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75339

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GERTRUDE HEYSER N-803-Y

2. DATE OF DEATH June 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto. Gen. Hosp.

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3216 Gwynn Falls Parkway 15-37

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	April 13 89	60	2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ✓
10B. KIND OF BUSINESS OR INDUSTRY ✓
11. BIRTHPLACE (State or foreign country) Balto Md
12. CITIZEN OF WHAT COUNTRY? Usa.
13. FATHER'S NAME Wm Heyser
14. MOTHER'S MAIDEN NAME Catherine Ball
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ✓ (If yes, give war or dates of service) ✓
16. SOCIAL SECURITY NO. ✓
17. INFORMANT Blanche H. Stringer ADDRESS Bellona Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of Skull
DUE TO Laceration of Brain
(B) Subarachnoid Hemorrhage
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARILY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Garrison Blvd. & Liberty Heights
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 6-13-49 3:42 P.M.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Slipped & Fell, Fell from streetcar (car not in motion) (through open door) thereon and from

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE William J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED June 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 15/49	Druid Ridge	Pikesville Md

DATE RECEIVED BY REGISTRAR JUN 15 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR John D. Mitchell ADDRESS Home for Funerals Eutaw Place

VS 151.

186a

G75340

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75340

1. NAME OF DECEASED (Type or Print): Mary L. Parker

2. DATE OF DEATH: June 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 625 St. Johns Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Nursing Home

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 625 St. Johns Road B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.

D. STREET ADDRESS (If rural, give location): 626St. Johns Road 27-13

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	Single	April 21. 1860	89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		Balto. Md.	U.S.

13. FATHER'S NAME: Edward N. Parker

14. MOTHER'S MAIDEN NAME: Louisa Lackland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no	no	no

17. INFORMANT: Safe Deposit & Trust Co. ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis

DUE TO Myocarditis

(B) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Gradual

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 7, 1943 *to* June 14, 1949 *that I last saw the deceased alive on* June 12 1949, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. H. Moody M. D. | 23B. ADDRESS: 1403 Park ave | 23C. DATE SIGNED: June 16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
burial	June 15.49	Green Mount Cemetery	Greenmount Ave. & Oliver St.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 15 1949

REGISTRAR'S SIGNATURE: Remington Williams, M.D.

25. FUNERAL DIRECTOR: John O. Mitchell & Sons ADDRESS: 1900 Eutaw Place

John O. Mitchell

VS 150*

937

Please write the cause of death clearly and correct age is especially important. Physician:

G75341

75341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75341

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT F. HENSON

2. DATE OF DEATH June 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital
Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1132 W. Mosher St. 16-01

5. SEX M
6. COLOR OR RACE col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH 6/18/25
9. AGE (In years last birthday) 23 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Henson

14. MOTHER'S MAIDEN NAME Louise Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW 2

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT ADDRESS Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) 1- Tuberculous meningitis — 11 mos.
DUE TO
(B) 2- Miliary tuberculosis, treated — 11 mos.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 13, 19 49 *to* June 14, 19 49, *that I last saw the deceased alive on* June 14, 19 49, *and that death occurred at* 9:25A m., *from the causes and on the date stated above.*

23A. SIGNATURE John L. Wilson M. D.
23B. ADDRESS US Marine Hospital, Balto, Md.
23C. DATE SIGNED 6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify) B.
24B. DATE 6-17-49
24C. NAME OF CEMETERY OR CREMATORY Balto. National
24D. LOCATION (City, town or county) (State) Balto. City

DATE RECEIVED BY LOCAL REGISTRAR JUN 15 1949
REGISTRAR'S SIGNATURE Thurlington Williams, M.D.
25. FUNERAL DIRECTOR Samuel W. Sullivan & Son
ADDRESS 1011 N. Arlington Ave 130

VS 150

Please write the cause of death clearly and fully. Physician: please write correct age in especially important.

BIRTH NO. 1075-42

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1075-42

1. NAME OF DECEASED (Type or Print)	Annie Bunting	2. DATE OF DEATH	June 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2218 McCulloh St. 14-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Widowed	1873	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		a.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
-----	-------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
Emil Reyer M.D.		June 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/16/49	Mt. Auburn Laurel Cem	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 15 1949	Huntington Williams, M.D.	Geo. G. Kelson	1303 Presstman St.

VS 151

Please write the cause of death clearly and legibly. Physicians: please write the exact age is especially important.

G75343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75343

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARIA A. WOODBRIDGE

2. DATE OF DEATH JUNE 14-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1409 W. Lombard St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

c. Length of stay in Baltimore Yrs. about 6 mos. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1409 W. Lombard St 19-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Feb 20-1867	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	—	England	—

13. FATHER'S NAME John C. Bonnet

14. MOTHER'S MAIDEN NAME Maria Raabe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT Mrs W. Clark Main ADDRESS 1409 W. Lombard St

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arterio-sclerotic Cardio-vascular Disease

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 8, 1948, *to* June 8, 1949, *that I last saw the deceased alive on* June 8, 1949, *and that death occurred at* 12:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Carl Rostling M. D.	1316 W Lombard St	6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 16-1949	Fort Lincoln Cem.	Washington D.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 15 1949	[illegible] M.D.	Geo. L. Berger Jr	1512 Baltimore St.

VS 150

937

Please write the cause of death clearly and legibly. Physician: please write exact age is especially important.

G75344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75349

BIRTH NO. B.C.49-11729

1. NAME OF DECEASED (Type or Print): Baby Boy Paul

2. DATE OF DEATH: June 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR [redacted]: St. Joseph's (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 2 hr. 50 min. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
c. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 119 E. Hughes St. 22-01

5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 12, 1949
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.: 2 50

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): St. Joseph's Hosp., Balto.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Joseph Paul
14. MOTHER'S MAIDEN NAME: Elizabeth Marian Rebuck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

(Physicians: please write the cause of death clearly and legibly. Correct age is especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 12, 1949 *to* June 12, 1949 *that I last saw the deceased alive on* June 12, 1949 *and that death occurred at* 5:50p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Daniel Ehrlich M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: June 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-17-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 15 1949
REGISTRAR'S SIGNATURE: Hamilton for Williams M.D.
25. FUNERAL DIRECTOR — ADDRESS: Leonard J. Ruck - 5305 Harford.

VS 150

161a

G75345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75345

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN DAVID ROYAL — N-803.4

2. DATE OF DEATH June 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospital

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Middle River
D. STREET ADDRESS (If rural, give location)

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 16, 1920
9. AGE (In years last birthday): 28 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Vance Royal
14. MOTHER'S MAIDEN NAME: Creasy Wright
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 245-16-9011
17. INFORMANT: Alice Collins Royal — ADDRESS

MEDICAL CERTIFICATION

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture, skull
DUE TO
(B) Subarachnoid Hemorrhage
DUE TO
(C) Contusion of brain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

N

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): highway
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Martin Boulevard, near Essex Balto. Co.
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: June 12, 1949 12.30am
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Automobile ran off road (Driver)

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Dillon J. McClafferty, M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: June 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 6/1549
24C. NAME OF CEMETERY OR CREMATORY: Norton
24D. LOCATION (City, town, or county) (State): Norton Va.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John E. Goff
ADDRESS: 413 Eastern Ave. Baltimore 21, Md.

VS 151

171C

G75346 G75346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 332

Registered No. 1

BIRTH NO.

1. NAME OF DECEASED (Type or Print) — Toba Meyerson

2. DATE OF DEATH — 6/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — MGH
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — Md
B. COUNTY — 13.01
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Baltimore
D. STREET ADDRESS (If rural, give location) — 2517 Madison Ave #17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	married		73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Russia	

13. FATHER'S NAME — Not known

14. MOTHER'S MAIDEN NAME — Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS — Hettie Zamerman wife 2517 Madison Ave

MEDICAL CERTIFICATION

Write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 7, 19 49 *to* June 15, 19 49, *that I last saw the deceased alive on* June 8, 19 49 *and that death occurred at* 2:20 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hale J. Black M. D.	Maryland General	6-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-16-49	Hebrew Friendship	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 15 1949	[redacted]	Jack Lewis Inc	2100 Eutaw Pl

VS 150

83-B

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Moore, Miss Mary Teresa

2. DATE OF DEATH June 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home for Incurables - 700 W 40th St.
C. Length of stay in Baltimore life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1901 Edgewood Ave. 15-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Single.	April 14, 1874	75 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Forlady - Mens Clothing Store	none	Baltimore, Md.	U.S.A.

13. FATHER'S NAME John H. Moore

14. MOTHER'S MAIDEN NAME Mary Virginia Boone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		none	S. Elizabeth Ross -	Home for Incurables.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 Month

DUE TO

(B) Arteriosclerosis (generalized) — 3 years

DUE TO

(C) Pagets Disease — 11 Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 11 19~~48~~49 *to* June 14, 1949 *that I last saw the deceased alive on* June 14, 1949 *and that death occurred at* 5 30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Grafton Hershey M. D.	214 Medical Arts Bldg	June 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/16/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 15 1949	Tuttington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

94a

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G75548 BALTIMORE CITY HEALTH DEPARTMENT 603
BIRTH NO. CERTIFICATE OF DEATH Registered No. G75548

1. NAME OF DECEASED (Type or Print) John T. Monsell — 2. DATE OF DEATH 6-15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West. Baltimore Gen. Hosp.
C. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3307 Clifton Ave #16 15-9

5. SEX M — 6. COLOR OR RACE W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 3-24-'75 — 9. AGE (In years last birthday) 74 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired — 10B. KIND OF BUSINESS OR INDUSTRY Printer
11. BIRTHPLACE (State or foreign country) Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Morsell Balto. Md.
14. MOTHER'S MAIDEN NAME Josephine Buckley Balto. Md.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.
17. INFORMANT Hospital Records — ADDRESS

MEDICAL CERTIFICATION — Please write the cause of death clearly and legibly. Physician: please write in detail. It is especially important that the correct age is entered.

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Bilateral Kidney disease
DUE TO
(C) Cystic Right Kidney

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic nephritis & pleural effusion

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. — 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-11-49, 19__, to 6-15-49, 19__, that I last saw the deceased alive on 6-15-49, 19__, and that death occurred at 1:35 A.m., from the causes and on the date stated above.

23A. SIGNATURE Boaz Linn Grant - M.D. M. D. — 23B. ADDRESS West. Baltimore Gen. Hosp. — 23C. DATE SIGNED 6-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE 6-17-49 — 24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. — 24D. LOCATION (City, Town, or county) (State) Switland, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 15 1949 — REGISTRAR'S SIGNATURE Washington Williams M.D. — 25. FUNERAL DIRECTOR Wm. J. Tickner & Sons. — ADDRESS Balto. Md.

VS 150

131a

G75349 G75349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) LUTHER ELONZO BURGESS

2. DATE OF DEATH June 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1411 Riverside Ave. 24-C

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	10/14/82	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Master	Seafarer	NC	USA

13. FATHER'S NAME John Burgess

14. MOTHER'S MAIDEN NAME Fannie Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown		217-14-9607		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma of the left lung with metastases to right axillary lymph node and right chest wall — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June. 18, 19 49 *to* June 13, 19 49 *that I last saw the deceased alive on* June 13 19 49, *and that death occurred at* 8:35A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M. D.	US Marine Hospital, Balto, Md.	6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B.	6-16-49	Cedar Hill	Brooklyn.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 15 1949	Carlton Williams, M.D.	Agnes L. McEnely	130 E. Fort Ave.

VS 150

47D

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G75350 CERTIFICATE CORRECTED 6-21-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH - 33

Registered No. G75350

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Anna C. Hammond

2. DATE OF DEATH 6/14/49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 714 Brookwood Rd
C. Length of stay in Baltimore (Life) 3 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2804
D. STREET ADDRESS (If rural, give location) 714 Brookwood Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	W.	Widow	Sept. 24, 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		(Md) Pennsylvania	

13. FATHER'S NAME Slicer

14. MOTHER'S MAIDEN NAME Hilbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Alice Barnhardt ADDRESS 714 Brookwood Rd.

MEDICAL CERTIFICATION

(Effect age is especially important. Physician: please write the cause of death clearly and fully.)

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 1, 1947, 19__, to 6/17, 1949 *that I last saw the deceased alive on* 6/17/49, 19__, *and that death occurred at* 10:20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
N. P. Van Schaaffland M.D.	4818 Edmondson Ave	6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	6/16/49	UNION CEM.	MEYERSDALE, PENNA

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 15 1949	Huntington Williams, M.D.	Harry H. Mintzer	4101 Edmondson Ave.

VS 150

83a

BIRTH NO. G75351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75351

1. NAME OF DECEASED (Type or Print): James H. Burch

2. DATE OF DEATH: June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Md. general Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland general Hospital
c. Length of stay in Baltimore: 29 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 511 Arlington avenue 27-20

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White		11-29-69 ?	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Not Known retired		Baltimore	Amer.

13. FATHER'S NAME: James E Burch

14. MOTHER'S MAIDEN NAME: Mary Long

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
unknown		Daughter & wife	511 Arlington ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Uremia & cardiac decompensation	1 week +
DUE TO (B)	Nephrosclerosis & chronic nephritis	5-6 mos +
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Hypertensive arteriosclerotic cardio-vascular renal disease	10 - 15 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Papilloma of rectum?	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 12, 1949 *to* June 15, 1949 *that I last saw the deceased alive on* June 15, 1949, *and that death occurred at* 9:20 A *m., from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
Marguerite Louise Candler	Maryland general Hospital	6-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-18-49	New Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
	Huntington Williams, M.D.	John A. Moran	3000 E. Balt. St.

VS 150

131a

Physicians please write the cause of death clearly and legibly. Correct age is especially important.

G75352

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 G75352

Registered No.

1. NAME OF DECEASED (Type or Print) JOHN MCKENNA

2. DATE OF DEATH June 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
West Baltimore General Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1317 Ramblewood Road 2 7-38

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
male	white	married	July 20, 1913	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman

10B. KIND OF BUSINESS OR INDUSTRY Auto

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Eugene E. McKenna

14. MOTHER'S MAIDEN NAME Mildred Purcell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
James A. McKenna 4323 old York Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intraventricular hemorrhage

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED June 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-15-49	New Cathedral	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 15 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John R. Moran ADDRESS 509 Balt. St.

VS 151

83a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75353 BALTIMORE CITY HEALTH DEPARTMENT G75353

BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Seleam K. Rubaiz — 2. DATE OF DEATH 6-14-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore 14 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Virginia B. COUNTY Norfolk

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Norfolk, Virginia

D. STREET ADDRESS (If rural, give location) Monticello Hotel

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	about 1882	about 67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
City Coal, Wood & Ice Co. Norfolk, Va.	retired	Norfolk, Va.	U. S.

13. FATHER'S NAME not known

14. MOTHER'S MAIDEN NAME not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Mrs. Benjamin Baker	9 E Chase St. Baltimore, Md.

MEDICAL CERTIFICATION — Please write the cause of death clearly and legibly. Exact age is especially important. Physician: please write

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Sclerosis — 4 years

DUE TO

(C) Hypertensive Cardio Vascular Disease — Many years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John R. Smith, Jr. M. D.	Union Memorial Hosp. Balto. Md	6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	6/15/49	Forest Lawn Cem.	Norfolk, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 15 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

92D

BIRTH NO. G75554

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

581 Registered No. G75554

1. NAME OF DECEASED (Type or Print) MORRIS T POND

2. DATE OF DEATH 6/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2317 EUTAW PLACE 13-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	4/12/03	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TICKET AGENT	SAFEWAY TRAILWAYS	SOUTH CAROLINA	U. S. A

13. FATHER'S NAME WALTER POND

14. MOTHER'S MAIDEN NAME FANNIE MORRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
UNKNOWN		MARILLA E. POND	2317 EUTAW PL.

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician's signature is especially important. Please write the exact age is especially important.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH: 3 mo.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/1, 1949, *to* 6/15, 1949 *that I last saw the deceased alive on* 6/14, 1949 *and that death occurred at* 1:00 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul H. Herold M. D.	Maryland General Hospital	6/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
REMOVAL	6/15/49	Montlawn Memorial	Raleigh N. Carolina

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 15 1949	Kenneth Williams, M.D.	Wm Cook Inc	1217 St Paul St.

124 B

G75355

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75355

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **May B. Cary**

2. DATE OF DEATH **June 14, 1949**

3. PLACE OF DEATH: A. Baltimore City, Maryland **Baltimore, Maryland**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **12 Hillside Road, Roland Park**
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore, Maryland**
D. STREET ADDRESS (If rural, give location) **12 Hillside Road, Roland Park**

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Sept. 14, 1949 (1873)	75	9 / 2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
--		Baltimore	

13. FATHER'S NAME **Adolphus Marx**

14. MOTHER'S MAIDEN NAME **Fannie Ellinger**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no	--	--

17. INFORMANT — ADDRESS: **Frances Cary Bowen, 12 Hillside Road**

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) **Arteriosclerotic Cardio-Vascular Disease**
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
--	--	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 19 46 *to* June, 19 49, *that I last saw the deceased alive on* June 14 19 49 *and that death occurred at* 11:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William L. Helfrich M. D.	6006 Roland Ave	June 14, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
removal	6/16/49	St. Raymond's Cemetery	Westchester, New York

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JUN 15 1949	Huntington Williams, M.D.	Wm. Cook, Inc., 1217 St. Paul Street

VS 150

937

Correct age is especially important. Physician please write the cause of death clearly and legibly.

BC. 48-26679 G75356

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 87

Registered No. G75356

1. NAME OF DECEASED (Type or Print): Thomas E. Powell

2. DATE OF DEATH: June 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinia Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 8315 Phila. Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	single	Dec. 2, 1948		6 / 11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elmer L. Powell

14. MOTHER'S MAIDEN NAME: Leotta F. Kipp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute hemorrhagic nephritis — INTERVAL BETWEEN ONSET AND DEATH: one week

DUE TO

(B) ~~and~~ post-varicella infection

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST:

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 June, 1949, *to* 13 June, 1949, *that I last saw the deceased alive on* 13 June, 1949, *and that death occurred at* 4:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: William V. Gross, Jr. M. D.

23B. ADDRESS: Sinai Hospital

23C. DATE SIGNED: 14 June 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/16/49	Oak Lawn	7225 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 15 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR — ADDRESS: Clarence F. Hoffmann 1639 Broadway.

38E

G75357 ✓ 007 G75357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ruth Rodgers

2. DATE OF DEATH May 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1220 St. James Street 10-02 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	colored	U N K N O W N	U N K N O W N	26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L Rogers M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 29 May 49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State) JUN 9 1949

DATE RECEIVED BY LOCAL REGISTRAR JUN 15 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Commissioner of Health

ADDRESS

VS 151

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

13B ✓

G75358 BALTIMORE CITY HEALTH DEPARTMENT 41.1 G75358

BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) MR. (or) GUS GUSTINO A. LANZOTTI

2. DATE OF DEATH 6-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore 23 Yrs. 5 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE, 26-5
D. STREET ADDRESS (If rural, give location) 808 So. RAPPOLLA ST., BALT.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	WHITE	MARRIED	8-15-11	37 38	9	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) ~~ITALY~~ NEW YORK

12. CITIZEN OF WHAT COUNTRY? U.S. of A.

13. FATHER'S NAME SALVATORE SAMUEL LANZOTTI

14. MOTHER'S MAIDEN NAME — ROSE DiMICHAEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO

(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 213 09 6814

17. INFORMANT PATIENT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PERITONITIS, GENERALIZED — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

DUE TO

(B) RUPTURED ABDOMINAL VISCUS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Essential hypertension

19A. DATE OF OPERATION (a) 5-24-49 (b) 6-5-49

19B. MAJOR FINDINGS OF OPERATION ACUTE DUODENUM ULCER, GASTRIC DIVERTICULUM. GENERALIZED PERITONITIS FROM RUPTURED ABD. VISCUS

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-5 1949 *to* 6-13, 1949 *that I last saw the deceased alive on* 6-13, 1949, *and that death occurred at* 3 45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE Charles H. Watts, M. D.

23B. ADDRESS Union Memorial Hospital

23C. DATE SIGNED 6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE JUNE 17 1949

24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER

24D. LOCATION (City, town, or county) (State) 4300 BELAIR RD MD.

DATE RECEIVED BY LOCAL REGISTRAR JUN 15 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR Dipple Bro. ADDRESS 1800 FLORBARD ST

117B

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Released to Hosp. ✓ + ✓ G75359

G75359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Gary Joe Kuhn

2. DATE OF DEATH: June 15 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 12 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: W. Virginia
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairmont
D. STREET ADDRESS (If rural, give location): Route 1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	White	Single	7-4-38	10 11		11

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child	Child	W. Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wilbur Kuhn	Letha Newhouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	No		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure

DUE TO

(B) Ventricular fibrillation

DUE TO

(C) Cong. heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/3 1949, to 6/15 1949, *that I last saw the deceased alive on* 6/15 1949, *and that death occurred at* 11:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mitchell C. Sanford M.D.	JOHNS HOPKINS HOSPITAL	6/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-15-49	Fairview Park	Funeral Home Shinston W. Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
		Earl B. Wolverton	403-E-25th St.

Medical Ex. Case To be approved 15TE

Please write the cause of death clearly and legibly. Physician: please write age is especially important.

G75360 ✓ 81 G75360

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Amanda Gantt

2. DATE OF DEATH: 6-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: 2 Yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-9
D. STREET ADDRESS (If rural, give location): 1228 E. Preston Street.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Widowed	April 9, 1867	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Va.	

13. FATHER'S NAME: Fred Adams

14. MOTHER'S MAIDEN NAME: Elizabeth Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G75361 ✓ 9.2.✓ G75361

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E Registered No.

1. NAME OF DECEASED (Type or Print) JOSEPH WALKER — N-806.0

2. DATE OF DEATH June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-5
D. STREET ADDRESS (If rural, give location) 1603 St. Paul Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Married	Nov 29th 1910	39	6	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Drahery Man	C.J. Benson	N.C.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph L. Walker	Lida (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	W.W. #2		Maxine S. Walker	1603 St. Paul St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Cervical Spine

DUE TO

(B) Crushed Cervical Cord

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ ~~CAUSE OF~~ DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Bridge at Calvert & Guilford Aves.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) June 14, 1949 m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Fell off a bridge while drunk

22. *I certify that I took charge of the remains described above, held an* PAR. autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L. Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED June 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Removal	6/16/49	Walkers Tyrrell Co Columbia	North Carolina

DATE RECEIVED BY LOCAL REGISTRAR JUN 16 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm Cook Inc. — ADDRESS 1217 St. Paul st.

VS 151

186a ✓

Give the cause of death clearly and legibly. Physician: please write the exact age if especially important.

G75362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 981.0 G75363 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Diggs N-803

2. DATE OF DEATH June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-10
D. STREET ADDRESS (If rural, give location) 3212 Leverton Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	Dec 19th 1903	45	5	26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Glazier	Ridge Const. Co.	Balto. Md.	

13. FATHER'S NAME Marion Diggs

14. MOTHER'S MAIDEN NAME Mamie Richardson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT — ADDRESS
Mrs. Loretta M. Diggs 3212 Leverton Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Compound Fracture of skull
DUE TO Laceration of Brain
(B) Due to Gun Shot
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Steps of 3212 Leverton Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) June 15, 1949 12:30 A.M.
21E. INJURY OCCURRED WHILE AT [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE William J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED June 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/18/49	Oak Lawn	Eastern Ave. Extended

DATE RECEIVED BY LOCAL REGISTRAR JUN 16 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS Wm. Cook Inc. 1217 St. Paul St.

VS 151

166

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75363 BK 123648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33

Registered No. G75363

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lena Simms

2. DATE OF DEATH 6- 15- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 50 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-3
D. STREET ADDRESS (If rural, give location) 326 Whitridge Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year - Months	If Under 1 Year - Days	If Under 24 Hours - Hours	If Under 24 Hours - Min.
Female	White	Widowed	April 14-1862	87				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) W shington D. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Diglemann

14. MOTHER'S MAIDEN NAME M ry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT B.C.H. Records ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis

DUE TO

(B) Hypertension.

DUE TO

(C) Hypertensive Heart Disease Slight Heart failure.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 Days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10- 11- , 1948, *to* 6- 15- , 1949, *that I last saw the deceased alive on* 6- 15- 1949, *and that death occurred at* 10.50 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE R. S. Rogers M. D.

23B. ADDRESS B.C.H. 4940 Eastern Ave.

23C. DATE SIGNED 6- 15- 1949

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify) Burial

24B. DATE 6/15/49

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 16 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1217 St. Paul St

VS 150

93D

Please write the cause of death clearly and correct age is especially important. Physician:

G75364

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

17° Registered No. G75369

1. NAME OF DECEASED (Type or Print): Tillie Potemken

2. DATE OF DEATH: June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3823 Beehler Avenue

c. Length of stay in Baltimore: 40 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3823 Beehler Avenue 28-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years, last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Widowed	June 5, 1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife		Russia	

13. FATHER'S NAME: Riskin

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Dena Bronstein	3823 Beehler Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Breast — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 21, 1948, *to* June 15, 1949, *that I last saw the deceased alive on* June 15, 1949, *and that death occurred at* 9 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Manuel Levin M. D.	4818 Reisterstown Rd	Jun 15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/16/49	Hebrew Young Men.	Windsor Mill Road.

DATE RECEIVED BY REGISTRAR: JUN 17 1949

REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.

25. FUNERAL DIRECTOR: Sol Levinson & Bros. ADDRESS: 1124 North Avenue

JUN 16 1949

50

Please write the cause of death clearly and legibly. Physician's signature is especially important.

G75365 ✓ G75365

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mary Rita Schmedes

2. DATE OF DEATH: June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1742 Darley Ave. E-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	Single	Feb. 13, 1919	30		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Copy Holder	Sun Office	Baltimore	

13. FATHER'S NAME: Adam Schmedes

14. MOTHER'S MAIDEN NAME: Katherine Quinn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Adam Schmedes	above

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Spontaneous Subarachnoid Hemorrhage — Interval between onset and death: 4 days

DUE TO

(B) Hemangioma of brain - right frontal lobe.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* June 12, 1949 *to* June 15, 1949 *that I last saw the deceased alive on* June 15, 1949, *and that death occurred at* 5:55a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ray C. Parsons Jr. M. D.	1400 N. Caroline St.	June 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 18	New Cathedral	Frederick Co.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 16 1949	Tuttington Williams, M.D.	Geo. M. Fink & Son	511 N. Wolfe

VS 150

567

G75366

BALTIMORE CITY HEALTH DEPARTMENT 51 G75366

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MR. GEORGE A. REDMAN

2. DATE OF DEATH 6-13-49

3. PLACE OF DEATH: A. Baltimore City; Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 13-5
D. STREET ADDRESS (If rural, give location) 720 PACIFIC STREET,

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	WHITE	MARRIED	12-11, 1882	66	7	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer.
10B. KIND OF BUSINESS OR INDUSTRY Ship Repairing
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S. of A.
13. FATHER'S NAME GEORGE REDMAN
14. MOTHER'S MAIDEN NAME MARIAN BUTLER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Lillie M. Redman ADDRESS 720 Pacific St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dissecting aneurysm of descending aorta with rupture. — INTERVAL BETWEEN ONSET AND DEATH: 1 month.

DUE TO

(B) Generalized severe arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coronary artery disease.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-12-49	DISECTING ANEURYSM OF THE ABDOMINAL AORTA	YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-12, 1949, *to* 6-13, 1949 *that I last saw the deceased alive on* 6-13, 1949 *and that death occurred at* 6:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles N. Watt Jr. M.D.	Union Memorial Hospital	6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/16/49	St Mary's	Hampden.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 16 1949	Huntington Williams, M.D.	Paul C. Thompson Jr.	3615-17 Chestnut Ave

VS 150

30D

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G75367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54.4

Registered No. G75367

BIRTH NO. B.C. 49-12019

1. NAME OF DECEASED (Type or Print) CHRISTOPHER STEPHEN MANGER

2. DATE OF DEATH 6-15-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hospital for Women of Maryland

C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 29.
D. STREET ADDRESS (If rural, give location) 4615 Old Frederick Rd 284

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M.	W	S	June 14 1949.				22	48

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	U. S. Maryland	U.S.

13. FATHER'S NAME Harry Christopher Manger.

14. MOTHER'S MAIDEN NAME Carolyn Teresa Manger.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	—	Mother	as above.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician please indicate if special age is important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonitis, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Cardiac Anomaly. — congenital.

DUE TO

(C) Hydromnios, Acute Fever — 3½ weeks.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 6-13- 1949 *to* 6-15 1949, *that I last saw the deceased alive on* June 15, 1949 *and that death occurred at* 2.15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward Hochheimer M. D.	8 E Eager St.	6/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/16/49	New Cathedral	Balto.

DATE RECEIVED BY REGISTRAR (LOCAL REGISTRAR) JUN 18 1949 — REGISTRAR'S SIGNATURE Curtis Worthington for Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS
E. J. Fanning & Son - 1986. Lafayette Ave.

VS 150

157E

G75368 ✓ 1 G75368

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Priscilla Johnson

2. DATE OF DEATH June 12-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 27 N. Forest St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore, Maryland

C. Length of stay in Baltimore 50 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1035 W. Lexington Street 1R-2

5. SEX F

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify)

8. DATE OF BIRTH June 12 1865

9. AGE (In years last birthday) 84 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY Domestic

10. BIRTHPLACE (State or foreign country) N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Nettie J. Davis ADDRESS 602 N Fremont Ave

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician, please write the correct age if important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Degeneration ?

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH ?

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 7, 1949 *to* June 12, 49, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE E R Johnson M. D. | 23B. ADDRESS 403 Med Arts Bg | 23C. DATE SIGNED 6/12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE June 17th | 24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery | 24D. LOCATION (City, town, or county) (State) Westport Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 16 1949 | REGISTRAR'S SIGNATURE [illegible] Williams, M.D. | 25. FUNERAL DIRECTOR Joseph L. Russ | ADDRESS 1200 McCulloh St

93D

G75369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75369

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Elfner

2. DATE OF DEATH: June 13-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2112 Mt. Royal Av.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 33± (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-2
D. STREET ADDRESS (If rural, give location): 2112 Mt. Royal Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	married	July 10-1874	74	11 / 3	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Laborer	Paints	Cincinnati Ohio	U.S.

13. FATHER'S NAME: Don't Know

14. MOTHER'S MAIDEN NAME: Don't Know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		065-05-0696	Mrs. Mary Elfner	2112 Mt. Royal Ave

MEDICAL CERTIFICATION

(Immediate cause is expected to be important. Physician please write clearly and legibly.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr. Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1945

DUE TO

(B) Chr. Interstitial Nephritis — 1945

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS - CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Apr. 30 1949 to June 13, 1949 that I last saw the deceased alive on June 13 1949 and that death occurred at 1:30 P. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul Brown M. D.	1630 W. North Av.	6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June-16-1949	Lorraine Park	Woodlawn-Balto. Co.-Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 16 1949 VS 15d	Timothy F. Williams, M.D.	Stewart + Mowen Co.	108 W. North Av. Balto. 1 Md.

1310

G75370 SAMMeth 59 G75370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ALBERTA LAMMETH

2. DATE OF DEATH 6/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 9-1
D. STREET ADDRESS (If rural, give location) 3901 Greenmount Ave #18

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
F	W		9/2/20	28	4			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H.W.			

13. FATHER'S NAME C. H. Surgey

14. MOTHER'S MAIDEN NAME Clara Rosenberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

(Correct age is especially important. Physician please write the cause of death clearly and legibly.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO (B) Chronic Glomerulo-nephritis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of uterus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/9 *19*49 *to* 6/14 *19*49, *that I last saw the deceased alive on* 6/14 *19*49, *and that death occurred at* 5:45 *P.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles J. Blank M.D.	Maryland General	6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 18, 1949	Holy Redeemer	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 16 1949

REGISTRAR'S SIGNATURE Turlington Williams, M.D.

25. FUNERAL DIRECTOR Welch Funeral Home ADDRESS 2617 Pennsylvania Ave

VS 150

480

G75371 ✓ X E902 G75371

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

N-821.0

1. NAME OF DECEASED (Type or Print): MARY F.C.GRITZAN

2. DATE OF DEATH: June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Edgewood Nursing Home

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland.
B. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chase
D. STREET ADDRESS (If rural, give location): 336 B Bay Drive Road.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year Months Days	If under 24 Hours Hours Min.
Female	White	Widowed	Aug. 28, 1860	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home		Baltimore, Md.	

13. FATHER'S NAME: John Frederick Hammel

14. MOTHER'S MAIDEN NAME: Caroline Eckert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No.		

17. INFORMANT: Mrs. John F. Wroten, 336 B Bay Drive ADDRESS: Chase, Md.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

DUE TO Chronic Interstitial Nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Fracture rt. hip.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
G.H. Merrill M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Home	336 B. Bay Drive Chase

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
May 4, 1949 p. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Slipped off glider on porch.

22. *I hereby certify that I attended the deceased from* June 3, 1949, *to* June 15, 1949, *that I last saw the deceased alive on* June 14, 1949, *and that death occurred at* 12:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Karl H Berman MD M. D.	5111 York Rd.	June 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 17, 1949	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 16 1949	Huntington Williams, MD	Ullrich Funeral Home 2008 Orleans St.,

VS 150

186a

G75372 Althoff D10 ✓

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C.H.-81047 **CERTIFICATE OF DEATH** Registered No. G75372

1. NAME OF DECEASED (Type or Print) Catherine Althoff

2. DATE OF DEATH 6-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2816 Kennedy Ave 9-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	June 14, 1947	2 yrs	-	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		MD	U.S.

13. FATHER'S NAME Charles R Althoff

14. MOTHER'S MAIDEN NAME Helen E. Hastie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Charles R. Althoff - 2816 Kennedy Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tbc Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 3 mos

DUE TO

(B) Miliary Tbc

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-8, 1949 *to* 6-14, 1949 *that I last saw the deceased alive on* 6-14, 1949, *and that death occurred at* 5:20 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
P. G. Petersen M. D.	University Hospital	6-14

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	June 17/49	Holy Redeemer	Belair Rd Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 16 1949	Huntington Williams, MD	Austin E. Donovan - 3638 Roland Ave

VS 150

13B

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75373

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

G75373

Registered No.

1. NAME OF DECEASED (Type or Print) George W. Wilson

2. DATE OF DEATH June 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1514 Division St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-1
D. STREET ADDRESS (If rural, give location) 208 McMechen

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Negro	Married	3/6/1886	63	3 4	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jessie Wilson

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Failure

DUE TO

(B) Hypertensive Cardiovascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 6/5, 1949 *to* 6/14, 1949, *that I last saw the deceased alive on* 6/14, 1949, *and that death occurred at* 1245 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Dr. Marcus W. Moore Sr M.D.

23B. ADDRESS Provident Hospital

23C. DATE SIGNED 6/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE 6/18/49

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn

24D. LOCATION (City, town, or county) — (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 16 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR A. A. Jackson

ADDRESS 916 Lemmon Ave.

VS 150

930

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75374

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edward Cookman Greenstreet

2. DATE OF DEATH 6-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12 27-12
D. STREET ADDRESS (If rural, give location) 323 Woodmoor Rd.

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 23, 1903
9. AGE (In years last birthday) 45 yrs.
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10B. KIND OF BUSINESS OR INDUSTRY Chicago Products Co.
11. BIRTHPLACE (State or foreign country) Maryland (Baltimore)
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John W. Greenstreet
14. MOTHER'S MAIDEN NAME Victoria Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Myrtle Greenstreet ADDRESS 323 Woodmoor Rd. Balto. 12, Md.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

DUE TO

(B) Earlier Myocardial Infarction — 3 mos.

DUE TO

(C) Coronary Sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE John R. Smith Jr. M. D.
23B. ADDRESS Union Memorial Hospital Balto. Md.
23C. DATE SIGNED 6-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/18/49
24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.
24D. LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR. JUN 15 1949
REGISTRAR'S SIGNATURE Carlyton Williams, MD
25. FUNERAL DIRECTOR WM. J. TICKNER & SONS
ADDRESS Balto., Md.

94a

G75375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75375

Registered No. G 75375

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Ellen Di Blasio**

2. DATE OF DEATH **June 14, 1949**

3. PLACE OF DEATH: A. Baltimore City, Maryland **247 S. Robinson St.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **home**

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **247 S. Robinson St.**

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	10/31/1930	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Baltimore, Md.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Fiorindo Di Blasio**

14. MOTHER'S MAIDEN NAME **Theresa Mingarelli**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT **Theresa Di Blasio** ADDRESS **247 S. Robinson St.**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Mitral Stenosis**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Rheumatic Cardio vascular disease** — 6 yr.

DUE TO

(C) **Rheumatic Fever**

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/1/48, 19, *to* 6/14/49, 19, *that I last saw the deceased alive on* 6/14/49 19, *and that death occurred at* 1:10 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE **Henry J. Slowka** M. D.

23B. ADDRESS **333 S. East Ave.**

23C. DATE SIGNED **6/14/49**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24B. DATE **6/17/49**

24C. NAME OF CEMETERY OR CREMATORY **Holy Redeemer**

24D. LOCATION (City, town, or county) (State) **4430 Belair Road**

DATE RECEIVED BY LOCAL REGISTRAR **6/16/49**

REGISTRAR'S SIGNATURE **Huntington Williams M.D.**

25. FUNERAL DIRECTOR **Frank Della Noce** ADDRESS **322 S. High St.**

VS 150

92 B

G75376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75376

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JACOB MARNER

2. DATE OF DEATH 6-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2037 Wheeler Ave

C. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-4
D. STREET ADDRESS (If rural, give location) 2037 Wheeler Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed		80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Felman

14. MOTHER'S MAIDEN NAME Gitel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Lee Marner ADDRESS 2037 Wheeler Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH 9 years

DUE TO general arteriosclerosis

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 19 37 *to* 6-16- 49 *that I last saw the deceased alive on* 6-16- 1949 *and that death occurred at* 2 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE W. A. McClelland M. D.

23B. ADDRESS 2230 Eutaw Pl

23C. DATE SIGNED 6-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6-16-49

24C. NAME OF CEMETERY OR CREMATORY Roselawn

24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 16 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Lewis Inc

ADDRESS 2100 Eutaw Pl

VS 150

1937

Please write the cause of death clearly and legibly. Physician, please write. Correct age is especially important.

G753377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 · G753377 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Josephine Sweet

2. DATE OF DEATH June 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-4
D. STREET ADDRESS (If rural, give location) 419 Hiaber Street Heaver St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Single	JAN. 10 1908	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Henson Kelly
14. MOTHER'S MAIDEN NAME Nellie ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mary Jiles — 419 Heaber St. ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive cardiovascular disease.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/18/49	Mt. Calvary	Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 16 1949
REGISTRAR'S SIGNATURE Lennington Williams, M.D.
25. FUNERAL DIRECTOR A. Halstead — 918 Druid Hill Ave (931) ADDRESS

VS 151

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Important. Physicians: please write the cause of death clearly and legibly. Exact age is especially important.

G75378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75378 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Virginia Liebmann

2. DATE OF DEATH: 6/13/49

3. PLACE OF DEATH: A. Baltimore City, Maryland: Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctors Hospital

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-2
D. STREET ADDRESS (If rural, give location): 709 N Luzerne Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White		May 14, 1881	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Poole

14. MOTHER'S MAIDEN NAME: Johanna Bull

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Charles B Liebmann ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Arteriosclerotic Heart Disease — 3 yrs.

DUE TO

(C) Generalized Arteriosclerosis — 5 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 12 1943 to June 13, 1949 *that I last saw the deceased alive on* June 13, 1949, *and that death occurred at* 1 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Israel Rosen M. D.

23B. ADDRESS: 2413 E Monument St

23C. DATE SIGNED: 6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/16/1949	Baltimore	Baltimore Co.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Wendell J Heppel ADDRESS: 935-312 Highland Ave

VS 150

Please see that the cause of death is clearly and legibly written. Physician's signature is especially important. Please write distinctly.

BIRTH NO. G75379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75379

1. NAME OF DECEASED (Type or Print): Corine Darby

2. DATE OF DEATH: 6/13/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 604 W. Hoffman St.

c. Length of stay in Baltimore: 18 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 604 W. Hoffman St. 17-2

5. SEX: Femal
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: June 30 1899
9. AGE (In years last birthday): 49
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Kingstree Se
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sandy Burough
14. MOTHER'S MAIDEN NAME: Silvy Durough

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Norcessor James ADDRESS: 5122 Fuston St. Pila. Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aneurysm - Aortic — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs

DUE TO

(B) Hypertensive Cardiovascular Disease — 6 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10 -, 1944, *to* June 13, 1949, *that I last saw the deceased alive on* June 13, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Douglas Sheppard M. D.
23B. ADDRESS: 604 N. Fulton ave
23C. DATE SIGNED: 6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/16/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Elroy O. Wilson 1000 Brantly Ave

30D

G75380 ✓ G75380

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
981 Registered No.

BIRTH NO. G75380

1. NAME OF DECEASED (Type or Print) John Davis — N-861.4
2. DATE OF DEATH June 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 910 N. Wolfe Street 7-4

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

c. Length of stay in Baltimore 15 yrs. (Yrs. Mos. Days)

5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH Feb. 5-1909 | 9. AGE (In years last birthday) 40 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Forrest Va. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Walter Davis | 14. MOTHER'S MAIDEN NAME Julia Pondexter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Preston Davis | ADDRESS 871 Watts St

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Gunshot wound of aorta	
	DUE TO with cardiac tamponade	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Private Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 403 N. Central Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 6:40 p.m. 6-11-49
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE William J. McCafferty M.D. | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED June 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 6-12-49 | 24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem. | 24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 16 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Elroy O. Wilson | ADDRESS 1000 Broadway

VS 151

166

Please write plainly and be sure the cause of death is clearly and legibly stated. Exact age is especially important. Physician, please write

G75581 BALTIMORE CITY HEALTH DEPARTMENT G75581

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WALTER WEBSTER

2. DATE OF DEATH June 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore 18 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1403 Barnes Street 10-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Sept. 7, 1905	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Littleton N. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Reed Powers

14. MOTHER'S MAIDEN NAME Mary Webster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Mary Webster 1403 Barnes St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Massive hemorrhage into gastro-intestinal tract.	
ANTECEDENT CAUSES	DUE TO (B) Esophageal varices.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) Cirrhosis of liver.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR

23C. DATE SIGNED June 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE June 16-49

24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.

24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 16 1949

REGISTRAR

25. FUNERAL DIRECTOR Elroy O. Wilson ADDRESS 1000 Brayton

1248 V and

VS 151

153

G75382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75382

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Barbara Prinz

2. DATE OF DEATH June 13-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 719 S. Stricker St

C. Length of stay in Baltimore 43 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 19-3
D. STREET ADDRESS (If rural, give location) 719 S. Stricker St

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH Oct 2. 187?
9. AGE (In years last birthday) 76 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Hungary
12. CITIZEN OF WHAT COUNTRY? Europe

13. FATHER'S NAME Frederick Becker

14. MOTHER'S MAIDEN NAME Catherine Eberle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None

17. INFORMANT Peter Prinz 719 S. Stricker St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma Ascending Colon	6 mos
ANTECEDENT CAUSES	DUE TO (B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) Diabetes Mellitus	10 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10 19 49 to June 13, 19 49, *that I last saw the deceased alive on* June 13 19 49 *and that death occurred at* 7:05 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE Chas A Cahn M. D.
23B. ADDRESS 2175 W Balto St
23C. DATE SIGNED 6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 17. 1949
24C. NAME OF CEMETERY OR CREMATORY New Cathedral
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 18 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR Robt Chas B. M. Walter
ADDRESS 1501 Stricker St

VS 150

46E

G75383

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75383

1. NAME OF DECEASED (Type or Print): GEORGE J. ZELLINGER

2. DATE OF DEATH: 6-14-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 526 S. DECKER AVE.

C. Length of stay in Baltimore: Yrs. LIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 1-2
D. STREET ADDRESS (If rural, give location): 526 S. DECKER AVE.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	7-13-1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINIST

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARTIN ZELLINGER

14. MOTHER'S MAIDEN NAME: ROSE ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: MARY ZELLINGER ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Acute Coronary Occlusion	3 days
DUE TO (B)	Arteriosclerotic Heart Disease	5 yrs
DUE TO (C)	Generalized Arteriosclerosis	10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1940, *to* June 14, 1949, *that I last saw the deceased alive on* June 13, 1949 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE: Eshad Rosen M. D.

23B. ADDRESS: 2413 E. Monument St

23C. DATE SIGNED: 6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 6-18-1949

24C. NAME OF CEMETERY OR CREMATORY: OAK LAWN

24D. LOCATION (City, town, or county) (State): BALTO. CO.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 16 1949

REGISTRAR'S SIGNATURE: Tuntington Williams, M.D.

25. FUNERAL DIRECTOR: Lilly & Zeiler, Inc.

ADDRESS: 403 S. WOLFE

937

VS 150

G75384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

11 V Registered No. G75384

BIRTH NO. G75384

1. NAME OF DECEASED (Type or Print) MABEL FEIGLEY

2. DATE OF DEATH 6/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md a. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-5

c. Length of stay in Baltimore 28 Yrs. Mon. Days

D. STREET ADDRESS (If rural, give location) 1813 Guilford Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hsw.	Housework	York Co. Pa.	

13. FATHER'S NAME Theofolus Gladfelter

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Harry A. Kaylor	Balto. Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cardiac Failure	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Cardiovascular Renal Disease	
	DUE TO (C) Septic infarcts of Spleen Multiple ulcers of Stomach	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Diffuse adenocarcinoma of Lungs Gallstones Fibroid of Uterus	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, public bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give street location)
	Market Thurmont	Fell off bed

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
		Multiple Bruises.

22. I hereby certify that I attended the deceased from 6/11 1949 to 6/15, 1949, that I last saw the deceased alive on 6/15 1949 and that death occurred at 8:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles J. Black, M.D.	Maryland General	6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 18, 1949	Lutheran	Glen Rock, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 16 1949	Acting for Williams, M.D.	Geo. C. Keeple	Glen Rock, Pa.

VS 150

131a

Please write the cause of death clearly and legibly. Physician, please write correct age in especially important.

G75385 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1 Registered No. G75385

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LILLIAN C. DURHAM

2. DATE OF DEATH: June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3213 Hayward Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3213 Hayward Ave. 27-17

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 13, 1894
9. AGE (In years last birthday): 55 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John A. Meagher
14. MOTHER'S MAIDEN NAME: Mary C. Schott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mr. George N. Durham ADDRESS: 3213 Hayward Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 years.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 10 *1949; to* June 15 *, 1949 that I last saw the deceased alive on* June 15 *, 1949, and that death occurred at* 12:55 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Nathan Wolf M. D.
23B. ADDRESS: 4117 Belvedere Ave - Baltimore Md
23C. DATE SIGNED: 6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/18/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WILLIAM J. TICKNER & SONS ADDRESS: Balto. Md.

VS 150

94a

G75386 5-03432 ✓ + 54.4 G75386

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Ellen Meeks

2. DATE OF DEATH: JUN 16 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Halsted 3
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Ga.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Waycroff
D. STREET ADDRESS (If rural, give location): 304 Thomas, St.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: 9-24-45
9. AGE (In years last birthday): 3 — If under 1 year: Months / Days — If under 24 hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Ga.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James B Meeks
14. MOTHER'S MAIDEN NAME: Eunice Holt Lipsey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital Heart disease
DUE TO Pulmonary stenosis
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-7- 1949 *to* 6-16- 1949 *that I last saw the deceased alive on* 6-16- 1949 *and that death occurred at* 4 10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Carl M. Burnett M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 6/16/49
24C. NAME OF CEMETERY OR CREMATORY: Oakland Cem.
24D. LOCATION (City, town, or county) (State): Waycroff, Ga.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WILLIAM J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

157E.

G75387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75387

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Bertha H. Bishop

2. DATE OF DEATH 6/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ~~Baltimore~~ Halethorpe
D. STREET ADDRESS (If rural, give location) 4628 Magnolia Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital.

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH 8/2/94 | 9. AGE (In years last birthday) 54 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George W. Hammond | 14. MOTHER'S MAIDEN NAME Belle E.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT Mr. John W. Bishop, Jr. | ADDRESS 4628 Magnolia Ave Halethorpe

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HYPERTENSIVE CARDIO VASCULAR RENAL DISEASE

DUE TO

(B) TERMINAL UREMIA

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS. CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/8, 1949 *to* 6/16, 1949 *that I last saw the deceased alive on* 6/16, 1949, *and that death occurred at* 7:10 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE John W. Bishop M. D. | 23B. ADDRESS St. Agnes Hosp. | 23C. DATE SIGNED 6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 6/20/49 | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 16 1949 | REGISTRAR'S SIGNATURE Lucretia Williams, M.D. | 25. FUNERAL DIRECTOR WM. J. TICKNER & SONS | ADDRESS Balto., Md.

VS 150

1210

Correct age is especially important. Physician: Please write the cause of death clearly, and legibly.

CERTIFICATE CORRECTED 6-17-49

G75388 / BALTIMORE CITY HEALTH DEPARTMENT 4 / G75388

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Mr. William (Winfred) Harvey Worrell

2. DATE OF DEATH June 15-1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. 3

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 15-11

D. STREET ADDRESS (If rural, give location) 3506 Grantley Rd. Balto.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	8/25/03	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland (Brookeville)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William W. Harvey

14. MOTHER'S MAIDEN NAME Macie Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) none (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 171-10-9750

17. INFORMANT Mrs. Mildred Thomsen ADDRESS 3506 Grantly Rd.

MEDICAL CERTIFICATION

Correct age in especially important. Physician: please write

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure.

DUE TO

(B) Mitral Insufficiency.

DUE TO

(C) Rheumatic Heart Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 13th 1949 *to* June 15th 1949 *that I last saw the deceased alive on* June 15 1949, *and that death occurred at* 9.05 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE Carlos J. Castellano M. D. 23B. ADDRESS Bon Secours Hospital. 23C. DATE SIGNED June 15-1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 6/18/49 24C. NAME OF CEMETERY OR CREMATORY St. John's Cem. 24D. LOCATION (City, town, or county) (State) Olney, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 16 1949 REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

VS 150

92B

G75389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75389 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Arthur Whalley

2. DATE OF DEATH: June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3303 Lyndale Ave.

C. Length of stay in Baltimore: 29 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3303 Lyndale Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	June 17, 1902	46	11 29	— —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10B. KIND OF BUSINESS OR INDUSTRY: Slayman Co.
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Whalley
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no, or unknown): No.
16. SOCIAL SECURITY NO.: 215-09-1116
17. INFORMANT: Mildred C. Whalley ADDRESS: 3303 Lyndale Ave.

*MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Chronic Myocardial Disease	1943
DUE TO (B)	Arteriosclerosis	?
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-29-, 1943 *to* 6-14-, 1949 *that I last saw the deceased alive on* 6-14-, 1949 *and that death occurred at* 6:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sulton C. Bang M. D. | 23B. ADDRESS: 2117 Belair Rd | 23C. DATE SIGNED: 6-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 6-18-49. | 24C. NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial | 24D. LOCATION (City, town, or county) (State): Howard County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 16 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: George L. Schwab | ADDRESS: 2101 Frederick Ave

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G75390 BALTIMORE CITY HEALTH DEPARTMENT 15 6.1G75390
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Rebecca L. Walker
2. DATE OF DEATH June 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1804 Madison Ave.
C. Length of stay in Baltimore Yrs. 6 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-03
D. STREET ADDRESS (If rural, give location) 1804 Madison Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored		Feb. 1 1880	69 60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Winchester, Va	U. S. A.

13. FATHER'S NAME Louis Robinson
14. MOTHER'S MAIDEN NAME Elizabeth Garrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		Mrs. Elizabeth Green	1804 Madison Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hepatic Carcinomatosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 12 June, 1949 to 14 June, 1949, that I last saw the deceased alive on 14 June, 1949, and that death occurred at 8:45 p. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ben Rhodes Jr. M. D.	1215 Mead Ave	16 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/17/1949	Winchester, Va	Winchester, Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 16 1949	Huntington Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave

46F

G75391

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

581.0

Registered No. G75391

1. NAME OF DECEASED (Type or Print): BERVINA VIOLA LITTLE

2. DATE OF DEATH: JUNE 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE HOSPITAL FOR THE WOMEN OF MARYLAND

c. Length of stay in Baltimore: Yrs. — Mos. — Days 3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: CARROLL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): TANEYTOWN
D. STREET ADDRESS (If rural, give location): BOX 382

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
FEMALE	WHITE	MARRIED	MARCH 18 1872	77				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	—	MARYLAND.	U.S.A.

13. FATHER'S NAME: BENJAMIN BABYLON

14. MOTHER'S MAIDEN NAME: SARA FLEGIL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		VIOLA LONG	BOX 312 TANEYTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Laennec's Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 4 MOS.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/13, 1949, *to* 6/16, 1949, *that I last saw the deceased alive on* 6/16, 1949, *and that death occurred at* 12:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mark Ehrlet J. M. D.	Hosp. Women of Md	6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 19, 1949	Church of God Cemetery	Frizzellburg Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 17 1949	Huntington Williams, M.D.	D O Bartgis + Sons	New Windsor + Union Bridge, Md

VS 180

124a

G75392

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75392

1. NAME OF DECEASED (Type or Print) HELEN De St. PRIE ROLLINS

2. DATE OF DEATH June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 218 Ridgewood Rd.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 218 Ridgewood Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Jan. 15, 1857	92 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	

13. FATHER'S NAME: William Wyman

14. MOTHER'S MAIDEN NAME: Helen Sanderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Mr. N. S. Wheat	912 Keyser Bldg.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia (Terminal) — Interval between onset and death: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Cortico-Sclerosis — 1 year

DUE TO Hypostatic Pneumonia — 1 year

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Jan 12th, 1949 to Jan 15, 1949 that I last saw the deceased alive on Jan 15th, 1949, and that death occurred at 11 P. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Schaffer M. D.	130 N. Calvert St	June 17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	6/17/49	Floral Cem.	Pittsfield, N. H.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 17 1949	Wm. Lloyd Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

93D

G75393

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51 G75393
Registered No.

1. NAME OF DECEASED (Type or Print) Stephen P. Clark

2. DATE OF DEATH 6/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4231 York Rd
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore 52 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md.
D. STREET ADDRESS (If rural, give location) 27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W		May 13/1863	86	0	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	same	Cecil Co Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Pascil Clark	Anna E. Pluck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Nettie L. Clark 4231 York Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Obstruction of stomach.	Several months.
DUE TO	(B) Probably neoplastic. Surgical exploration was not undertaken and it was not possible to obtain a biopsy.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	(C) Malnutrition and cachexia.	Several weeks.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None.		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No.	No.	

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
None. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 24, 1949 *to* June 15, 1949, *that I last saw the deceased alive on* June 15, 1949, *and that death occurred at* ____ p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas E. Bayer M. D.	11 E. Chase St., Balto. 2, Md.	6.16.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/18/49	Morland Memorial Cem	Sec. N. 655

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 17 1949	Huntington Williams, M.D.	Chas P. Towell	2427 Edmondson Ave

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46B

G75394

BIRTH NO. G75394

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75394

1. NAME OF DECEASED (Type or Print): JAMES LESTER PROUTY

2. DATE OF DEATH: June 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore ? Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middle River
D. STREET ADDRESS (If rural, give location): 44 Stabilizer Drive

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3/15/04
9. AGE (In years last birthday): 45 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Welder
10B. KIND OF BUSINESS OR INDUSTRY: Maryland Drydock
11. BIRTHPLACE (State or foreign country): Balto, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Caleb Prouty
14. MOTHER'S MAIDEN NAME: Mamie Auld

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT — ADDRESS: Records US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hodgkin's disease — INTERVAL BETWEEN ONSET AND DEATH: More than 1 yr.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 18, 1949 *to* June 16, 1949 *that I last saw the deceased alive on* June 16, 1949, *and that death occurred at* 8:28 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson — John L. Wilson M. D.
23B. ADDRESS: US Marine Hospital, Balto, Md.
23C. DATE SIGNED: 6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 6/18/49
24C. NAME OF CEMETERY OR CREMATORY: MORELAND MEM
24D. LOCATION (City, town, or county) (State): PARKVILLE

DATE RECEIVED BY LOCAL REGISTRAR: JUN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: L. HEEMANN & SON.

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75395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 8 12:0 G75395

Registered No.

BIRTH NO.

N- 803.

1. NAME OF DECEASED (Type or Print): HUNTER HOLMES ARMSTRONG

2. DATE OF DEATH: June 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Owings Mills, Md.
D. STREET ADDRESS (If rural, give location): McDonough Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Singel
8. DATE OF BIRTH: July 10, 1942
9. AGE (In years last birthday): 6 yrs.
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore Co.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Douglas R. Armstrong

14. MOTHER'S MAIDEN NAME: Garretta M. Schmidt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Douglas R. Armstrong — ADDRESS

MEDICAL CERTIFICATION

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Duodenal ulcer, perforated, with hemorrhage -- smt
DUE TO (A) Fracture of skull
(B) Contusion of Brain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Subarachnoid hemorrhage -- smt

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Randallstown, Maryland Balto. Co.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 17, 1949 Approx. 8 A. m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by truck

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: June 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 26, 1949
24C. NAME OF CEMETERY OR CREMATORY: New Oakland
24D. LOCATION (City, town, or county) (State): Carroll Co.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: J.F. Eline & Sons Reistertown, M

VS 151

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Q75396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. Q75396

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nellie F. Mansfield Mrs. 1

2. DATE OF DEATH: June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3320 Erdman Ave.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3715 Marmon Ave. 28-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	May 18, 1892	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: 22-01=0824
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? —
13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.
17. INFORMANT: George Mansfield — ADDRESS: 3715 Marmon Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: William J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☒ / ASSISTANT MEDICAL EXAMINER ☐ / MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: June 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/18/49	Loudon Park	

DATE RECEIVED BY LOCAL REGISTRAR: JUN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Paul E. Schenuit Jr. ADDRESS: 845-47 Eastern Ave

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94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G75397

G75397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75397

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY F YEAGLE

2. DATE OF DEATH 6-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hosp.
c. Length of stay in Baltimore 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore # 11 13 06
D. STREET ADDRESS (If rural, give location) 3443 Chestnut Ave.

5. SEX Fe
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 12, 1874
9. AGE (In years last birthday) 75 If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas B. Duvall
14. MOTHER'S MAIDEN NAME Laura Sherwood
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Irma Pfeffer ADDRESS Church Home & Hosp.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH 10 min
DUE TO
(B) Fracture of rt hip — 1 month
DUE TO
(C) Hypertensive Cardiovascular Disease, Generalized arteriosclerosis, Diabetes mellitus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
For Dr. C. J. Lubinski
per W. J. McClafferty M. D.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3443 Chestnut ave 13/6
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 5-20-49 m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Fell placing rug on floor, own home

22. I hereby certify that I attended the deceased from 5-21-49, 19__, to 6-16, 1949, that I last saw the deceased alive on 6-16, 1949, and that death occurred at 12:15 p.m. from the causes and on the date stated above.

23A. SIGNATURE W. J. McClafferty M. D.
23B. ADDRESS Church Home
23C. DATE SIGNED 6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/18/49
24C. NAME OF CEMETERY OR CREMATORY London Park
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR JUN 17 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Paul E. Blanomett Jr.
ADDRESS 1615-17 Chestnut

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G75398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

177 Registered No. G75398

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MR. ERNEST GREEN

2. DATE OF DEATH: 6/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BON SECOURS HOSPITAL

C. Length of stay in Baltimore: 60 (15) Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 28-04
D. STREET ADDRESS (If rural, give location): 615 WINANS WAY

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	widow	2/2/70	79	-	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FORMER POSTMASTER	U. S. Post Office	VIRGINIA (Alexandria)	U.S.A.

13. FATHER'S NAME: MR. JAMES E. GREEN

14. MOTHER'S MAIDEN NAME: Anna Sophia Stringfellow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	no	MR. JAMES E. GREEN	615 Winans Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF PROSTATE — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1/4/49	CARCINOMA OF PROSTATE	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JUNE 15, 1949, to JUNE 16, 1949, *that I last saw the deceased alive on* JUNE 16, 1949, *and that death occurred at* 1:10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul A. Mannaro, M. D.	130N SECOURS HOSP.	6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/18/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 17 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

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G75399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

150 D

Registered No. G75399

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Stellman, Mr. George P.

2. DATE OF DEATH June 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home for Incurables, 700 to 4076 ST

C. Length of stay in Baltimore ~~Lifexx~~ Yrs. 3 Mos. 02 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 700 Fleet St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed	Nov 2, 1862	86				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	-	Germany.	U.S.A.

13. FATHER'S NAME: John Stellman

14. MOTHER'S MAIDEN NAME: Sarah Cappeau

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
none		none	Mary E. Wharton - Home for Incurables	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Left Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 5 Days

DUE TO

(B) Arteriosclerosis (generalized) — 6 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Cardiac Hypertrophy + Dilatation — 3 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct 24 1946 *to* June 16 1949, *that I last saw the deceased alive on* June 15, 1949, *and that death occurred at* 8 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Grafton Hershey M. D.	414 Medical Arts Building	6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/17/49	Greenmount Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 17 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

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G75400

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75400

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNIE SHOEMACK

2. DATE OF DEATH: June 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Methodist Home for the Aged 2211 W. Rogers Ave.
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 W. Rogers Ave. 27-15

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Dec. 29, 1875
9. AGE (In years last birthday): 73 yrs. (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George Shoemack
14. MOTHER'S MAIDEN NAME: Laura Jane Steer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Mamie B. Fisher ADDRESS: 2211 W. Rogers Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary thrombosis	4 days.
DUE TO (B)	arteriosclerosis	10 yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 2, 1947 *to* June 15, 1949 *that I last saw the deceased alive on* June 15, 1949, *and that death occurred at* 1 10A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Anthony J. Dawes M. D.
23B. ADDRESS: 8004 33rd St-11
23C. DATE SIGNED: 6-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/20/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 17 1949
REGISTRAR'S SIGNATURE: Turlington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

JHS 150

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G75401

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75401

1. NAME OF DECEASED (Type or Print) Mary C. Smith

2. DATE OF DEATH June 12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1453 Parrish St
C. Length of stay in Baltimore 12 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 15-01
D. STREET ADDRESS (If rural, give location) 1453 Parrish St.

5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 29 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Arthur Smith ADDRESS 917 Fallow Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculosis of Lungs
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 mo's

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 12, 19X9, *to* June 12, 19X9, *that I last saw the deceased alive on* June 12, 19X9 *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE E William Frey M. D.
23B. ADDRESS 1928 Penna Ave
23C. DATE SIGNED 6/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/17/49
24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery
24D. LOCATION (City, town, or county) (State) Geo. G. Kelson

DATE RECEIVED BY LOCAL REGISTRAR JUN 17 1949
REGISTRAR'S SIGNATURE Turlington Williams M.D.
25. FUNERAL DIRECTOR 1303 Pressman Address

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G75402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G75402 Registered No.

1. NAME OF DECEASED (Type or Print): Mary Lou Williams

2. DATE OF DEATH: June 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1317 Madison Ave.

Dan-Wil-Ba Nursing Home

C. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-0
D. STREET ADDRESS (If rural, give location): 220 N. Pearl Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	C	Widow	1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Abbeville, S.C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Lillian Matthews	2725 Fisk Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Hypertensive

DUE TO

(B) Cardio Vascular Renal — 1 yr.

DUE TO

(C) Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 4, 1949 *to* June 13, 1949 *that I last saw the deceased alive on* June 13, 1949, *and that death occurred at* 9:55 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert L. Dashiell M.D.	622 N. Eutaw St.	6-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-17-49	Mt. Zion Cem.	Sandsdare Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 17 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Mrs Katie R. Williams — ADDRESS: 327 N. Schroeder St

VS 150

131a

G75403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75403

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Johnson Constance

2. DATE OF DEATH June 14 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1519 Division St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) 929 Gilmore St 19-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Married	Oct 1 1897	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Howard County	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John H Smith	Clara Butts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No.	None	Mary Curtis 929 N. Gilmore St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Secondary Shock

DUE TO

(B) Intestinal Obstruction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 13, 1949, *to* June 14, 1949, *that I last saw the deceased alive on* June 14, 1949, *and that death occurred at* 8:03 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr Marcus W. Moore Sr M. D.	Provident Hospital	6/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 19, 1949	Western Star	Catonsville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 17 1949	Huntington Williams, M.D.	Mrs Katie R. Williams	932 N Schroeder St

VS 150

932

CERTIFICATE CORRECTED 6-30-49 ✓

G75404 BALTIMORE CITY HEALTH DEPARTMENT E 98 v.6 G75404

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Morris Carmichael N-869-7

2. DATE OF DEATH: June 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1333 ~~1331~~ Husker r Court r5-16

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	C	Married	May 5, 1917	31		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stevedore	Beth. Steel	Dillion, S. C.	

13. FATHER'S NAME: Carroll Carmichael, S. C.

14. MOTHER'S MAIDEN NAME: Florence Moody, S. C.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Mrs. Emma Carmichael	1331 Husker

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stab wound of liver

DUE TO Stab wound of lung, right

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Tavern

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3327 Remley Avenue (tavern)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 13,'49 12:01a. m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Sharp instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: June 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Shipped	6-18-49	Dillion	Dillion S. C

DATE RECEIVED BY LOCAL REGISTRAR: JUN 17 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Rose Katie R. Williams ADDRESS 322 N

VS 151

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G75405 29625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75405

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Samuel Green

2. DATE OF DEATH 6- 15- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1626 N. Gilmore ST. 15-01

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 18 1881
9. AGE (In years last birthday): 68 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Marshall Green
14. MOTHER'S MAIDEN NAME: Melvina ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records B.C.H. ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia & Uremic pericarditis
DUE TO
(B) Arteriolar nephrosclerosis
DUE TO
(C) Arteriosclerotic heart disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Perforated diverticulum of small bowel

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6- 13- , 1949, *to* 6- 15- , 1949, *that I last saw the deceased alive on* 6- 15- 1949, *and that death occurred at* 3.00 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Logan M.D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 6-16- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-18-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto Md
ADDRESS: 3224

DATE RECEIVED BY LOCAL REGISTRAR: JUN 17 1949
REGISTRAR'S SIGNATURE: Deputy for Williams, MD
25. FUNERAL DIRECTOR: Mrs Katie R. Williams

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13/a

G75406

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

143

G75406 Registered No.

1. NAME OF DECEASED (Type or Print): Martha Giles

2. DATE OF DEATH: 6/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp. 15-14 Division St

C. Length of stay in Baltimore: 77 yrs (Life) Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18 07
D. STREET ADDRESS (If rural, give location): 1115-W-Mulberry St

5. SEX: F
6. COLOR OR RACE: N
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 30, 1871
9. AGE (In years last birthday): 77 — If under 1 year: Months 11, Days 20 — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: un Known
14. MOTHER'S MAIDEN NAME: un Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Elsie Horsey ADDRESS: 1027-W. Saratoga

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial failure
DUE TO
(B) Hypertension
DUE TO
(C) Pulmonary edema

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 3/15/49
19B. MAJOR FINDINGS OF OPERATION: Ca of Left Breast
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/8, 1949, to 6/14, 1949, that I last saw the deceased alive on 6/14, 1949; and that death occurred at 10:00 m., from the causes and on the date stated above.

23A. SIGNATURE: Dr. M. Moore/Cochran M. D.
23B. ADDRESS: 15-14-Division St
23C. DATE SIGNED: 6/0/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 18, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mrs Kate R. Williams
ADDRESS: 3221 Edmondson Ave

VS 150

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G75407

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75407

1. NAME OF DECEASED (Type or Print): Bruce Craig

2. DATE OF DEATH: 6-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp.

C. Length of stay in Baltimore: Yrs. Mos. 3 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Havre de Grace
D. STREET ADDRESS (If rural, give location): RDF - Havre de Grace.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Single	Jan 3, 1949.	5 mos.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Havre de Grace

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Donald I Craig

14. MOTHER'S MAIDEN NAME: Rebecca Cooley Gilbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Donald I Craig ADDRESS: Same -

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Life

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-13 19 49 *to* 6-16 19 49 *that I last saw the deceased alive on* 6-16 19 49 *and that death occurred at* 10:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.

23B. ADDRESS: Mercy Hospital

23C. DATE SIGNED: 6-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE: 6-19-49

24C. NAME OF CEMETERY OR CREMATORY: Chapel

24D. LOCATION (City, town, or county) (State): Havre de Grace, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 17 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: Lena Patterson & Son

ADDRESS: 157 E. Aberdeen, Md.

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G75408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75408

STATE NO.

1. NAME OF DECEASED (Type or Print) LENA HERMAN

2. DATE OF DEATH 6-16-1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4700 HARFORD RD.

b. Length of stay in Baltimore UNKNOWN (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 417 S. ANN ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	MARRIED	3-22-1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	GERMANY	U.S.A.

13. FATHER'S NAME GEORGE EICKENBERG

14. MOTHER'S MAIDEN NAME WILHELMINA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			AUGUST HERMAN	SAME

MEDICAL CERTIFICATION

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15-June-49

DUE TO

(B) Arterio Sclerotic Cardio — 2-June-49

DUE TO Vascular Disease

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-June, 1949 *to* 16-June, 1949 *that I last saw the deceased alive on* 16-June, 1949 *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas. Pat Edwards M. D.	2746 The Alameda	17-June-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	6-20-49	PARKWOOD	BAL. TO. CO.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 17 1949	Huntington Williams, M.D.	Lilly J. Feiler Inc.	403 S. WOLFE

VS 150

93D

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Mrs. Regina MRS. FRANK A. DOYLE

2. DATE OF DEATH 6-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTIMORE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital
C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY MD BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 315 WOODBOURNE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	White	MARRIED	June 19, 1900	48	—	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	—	Baltimore, Md	U.S.A.

13. FATHER'S NAME JAMES S. HOLDEN

14. MOTHER'S MAIDEN NAME ANN KELLY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (Wife, Husband)	ADDRESS
—	—	—	Mr. Frank Doyle (Husband)	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HCVD & ASHD

DUE TO

(B) Chronic Nephritis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus; Degenerative Arthritis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 4/3 1949 *to* 6-16, 1949 *that I last saw the deceased alive on* 6-16, 1949 *and that death occurred at* 2:35 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	Union Mem. Hosp	6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
BURIAL	6-20-49	New Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 17 1949		John A. Moran	3000 Balt. St.

VS 150

61

BIRTH NO. G75410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 075410

1. NAME OF DECEASED (Type or Print): SHIRLEY GLAESER (SHIRLEY MAE GLAESER)

2. DATE OF DEATH: June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Linthicum
D. STREET ADDRESS (If rural, give location): NURSERY ROAD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	S	Dec/15, 1935	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): school girl
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Frederick Louis Glaeser
14. MOTHER'S MAIDEN NAME: Ethel E. Rau
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Nursery Rd. Linthicum, Md Frederick L. Glaeser

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull.
DUE TO
(B) Intracranial hemorrhage.
DUE TO
(C) Concussion of brain.
DUE TO
(D) Fractured pelvis.
Fractured left foot.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Hammons Ferry Rd. ½ mile south of Nursery Road
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 15, 1949 11a m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Struck by a truck

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: June 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 6/20/49
24C. NAME OF CEMETERY OR CREMATORY: Meadowridge Cemetery
24D. LOCATION (City, town, or county) (State): rural- Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 17 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC. BALTIMORE - 13, MARYLAND

VS 151

170c

LAMASA

G75411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

760 Registered No. G75411

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Matteo Lamasa

2. DATE OF DEATH June 15 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3307 Cressland Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 45 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 3307 Cressland Ave 8-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	April 2 1889	60	2	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Restaurant Business		Fantina Messina Italy	U.S.

13. FATHER'S NAME: Alberto Lamasa

14. MOTHER'S MAIDEN NAME: [redacted] Venera Catania

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Josephine Lamasa ADDRESS: 3307 Cressland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Diabetis, Cirhosis
DUE TO
(B) of the Liver
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) 4 mo.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from May 1, 1949 to 6-15-1949, that I last saw the deceased alive on 6-13-1949 and that death occurred at m. from the causes and on the date stated above.

23A. SIGNATURE: Fred Ruzzo M. D.
23B. ADDRESS: 800 N Milton Ave
23C. DATE SIGNED: 6-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 18 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State): 4430 Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Frank Della Rocca ADDRESS: 322 S. High St.

VS 150

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G75412 - BALTIMORE CITY HEALTH DEPARTMENT 177 Registered No. G75412

BIRTH NO.

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print): William F. Nichols

2. DATE OF DEATH: June 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 718 McCabe Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 718 McCabe Avenue

27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
male	white	single	Jan. 12, 1881	68	5	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Printer - retired	Gov't Printing Office	Baltimore, Maryland	

13. FATHER'S NAME: George F. Nichols

14. MOTHER'S MAIDEN NAME: Anna Wiedemeyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO		

17. INFORMANT — ADDRESS: Mrs. Anna Nichols, 718 McCabe Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 day.

DUE TO

(B) Cardiac hypertrophy — one year.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Carcinoma of Prostate — 2 years.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
4/30/48	Carcinoma of Prostate	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4/26, 1948, *to* 6/16, 1949 *that I last saw the deceased alive on* 6/15, 1949, *and that death occurred at* 2 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hilbert F. Bluelman M.D. M. D.	6 E Biddle St	6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	6/18/49	Loudon Park Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JUN 17 1949	Temporary for Williams, MD	Wm. Cook, Inc., 1217 St. Paul Street

VS 150

51B

G75413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75413 Registered No.

BIRTH NO. B.C.49-11455

1. NAME OF DECEASED (Type or Print): Baby Boy Westerman

2. DATE OF DEATH: June 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore: 2 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11
D. STREET ADDRESS (If rural, give location): 3902 Greenspring Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	White	S.	June 6, 1949			2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David Westerman

14. MOTHER'S MAIDEN NAME: Fan Weiner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Fan Westerman ADDRESS: 3902 Greenspring Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis
DUE TO

ANTECEDENT CAUSES

(B)
DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prematurity

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 6, 1949 *to* June 8, 1949 *that I last saw the deceased alive on* June 8, 1949 *and that death occurred at* 2:50 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sydney A. Warren M. D. | 23B. ADDRESS: Sinai Hospital - Baltimore | 23C. DATE SIGNED: June 9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL JUN 10 1949 | 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JUN 17 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Commissioner of Health | ADDRESS

VS 150

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G75414 — 76-5 — X — G75414

BIRTH NO. BC-49-11452

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Liberatore

2. DATE OF DEATH: June 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: 11 hrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20 Essex
D. STREET ADDRESS (If rural, give location): Oak Grove Apts. 304 A. Holly Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	S.	June 7, 1949			-	11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Allen Liberatore
14. MOTHER'S MAIDEN NAME: Virginia Wood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Virginia Liberatore ADDRESS: 304 A. Holly Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Prematurity

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 7, 1949, *to* June 7, 1949, *that I last saw the deceased alive on* June 7, 1949, *and that death occurred at* 1:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Sydney A. Warren M. D.
23B. ADDRESS: Sinai Hospital, Baltimore 2nd
23C. DATE SIGNED: June 9/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL JUN 10 1949
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JUN 17 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: [illegible] ADDRESS:

VS 150

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G75415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

571.0

G75415

BIRTH NO. BC.49-02228 Registered No.

1. NAME OF DECEASED (Type or Print): Paul Thomas Venere

2. DATE OF DEATH: June 15, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3135 Virginia Ave.

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 3135 Virginia Ave. 27-16

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year: If under 1 day: Last birthday)	Months	Days	Hours	Min.
male	white	single	Feb. 3, 1949	0	4	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Infant	--	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Joseph N. Venere.

14. MOTHER'S MAIDEN NAME: Mary Lamendola

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: --

17. INFORMANT: J.N.Venere, ADDRESS: 3135 Virginia Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — Interval between onset and death: 1 day

DUE TO

(B) Diarrhea — 5 days.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/ 15, 1949 *to* 6/15/49, 19__, *that I last saw the deceased alive on* 6/15/, 1949, *and that death occurred at* 5.15 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
F. L. De Barbieri M. D.	4723 Park Heights Ave.	6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	6/18/49	Holy Redeemer Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 17 1949	Huntington Williams, M.D.	C. Vernon Lennon	4611 Park Hgts.Ave.

VS 150

E 119a

G75416

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75416

1. NAME OF DECEASED (Type or Print) Frank Rodgers

2. DATE OF DEATH June 16 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pa.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hastings
D. STREET ADDRESS (If rural, give location) Mitchell St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	4-13-85	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner		Pa	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lawrence Rodgers	Amanda Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL ANOXIA

DUE TO

(B) HEART FAILURE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) ARTERIOSCLEROTIC HEART DISEASE

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

PNEUMOCONIOSIS

INTERVAL BETWEEN ONSET AND DEATH
(A) 3 wks,
(C)
20 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE	NONE	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-22 1949, *to* 6-16, 1949, *that I last saw the deceased alive on* 6-16, 1949, *and that death occurred at* 6 05 P, *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. H. Sefton M. D.	JOHNS HOPKINS HOSPITAL	6-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	June 17, 49	Hastings, Penna	Hastings, Penna

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 17 1949	Huntington Williams M.D.	Wm Cook Inc	

VS 150

93D

G75417

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75417

1. NAME OF DECEASED (Type or Print): Lola Russell

2. DATE OF DEATH: 6/13/49

3. PLACE OF DEATH: Baltimore City, Maryland - 432 N. Calhoun St.

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 31 years (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN: (If outside corporate limits, write RURAL and give township) Baltimore City 19-A
D. STREET ADDRESS (If rural, give location): 432 N. Calhoun St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Married	March 10 1890	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Painter Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Rogers
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: John Russell ADDRESS: 432 N Calhoun

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Hypertension — 2 mon, 3 da
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/10, 1949 to 6/13, 1949 that I last saw the deceased alive on 6/13, 1949 and that death occurred at 2:15 p.m. from the causes and on the date stated above.

23A. SIGNATURE: H Udelsmile M. D.
23B. ADDRESS: 1131 Harlem Ave
23C. DATE SIGNED: 6/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-17-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 18 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Elroy Gudson ADDRESS: 1005 Brantley Rd

VS 150

83a

G75418 — BALTIMORE CITY HEALTH DEPARTMENT — 416 — G75418

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Margarite Beckham — 2. DATE OF DEATH: June 14/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1516 E Chase St

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1516 E Chase St 8-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Single	May 8, 1925	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore Md	

13. FATHER'S NAME: Theodore Beckham

14. MOTHER'S MAIDEN NAME: Viola Duncan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Viola Beckham — ADDRESS: 1516 E Chase St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, Hypostatic & Congestive failure. — INTERVAL BETWEEN ONSET AND DEATH: 9 mos.

DUE TO

(B) Carcinoma of stomach & Generalized carcinosis (poss) — 6 mos.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1949 *to* June 14, 1949 *that I last saw the deceased alive on* June 14 1949 *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. LeRoy Perry M. D.	14 to E. Chase 13	6-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 18 49	New Cathedral Cem.	Frederick Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 18 1949

REGISTRAR'S SIGNATURE: Emmanuel Williams, Md

25. FUNERAL DIRECTOR: Mr Robt G. Elliott & Son — ADDRESS: 95 & 1127 W. Caroline St.

VS 150

G75419 CERTIFICATE CORRECTED 6-27-49 G75419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Victor J. Greiner

2. DATE OF DEATH 6/17/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 4908 Morello Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4908 Morello Rd.

c. Length of stay in Baltimore 40 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. City

D. STREET ADDRESS (If rural, give location) 4908 Morello Rd. 27-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	5/17/1876	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter (House)	Owner	Michigan	U.S.

13. FATHER'S NAME John Greiner

14. MOTHER'S MAIDEN NAME Elizabeth Boessel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mrs. Victor Greiner	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 4 Months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	None	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
—	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from May 18th, 1949 to June 17, 1949 that I last saw the deceased alive on June 17, 1949, and that death occurred at 5 P m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. L. Gordy M.D. M. D.	5106 Harford Road	6-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/20/49	Parkwood	Balto. City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 18 1949	Huntington Williams M.D.	Lassahn Funeral Home	7401 Belair

VS 150

93D

075420

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 075420

1. NAME OF DECEASED (Type or Print) Sue Sloan

2. DATE OF DEATH June 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4309 Nicholas Avenue

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4309 Nicholas Avenue 26-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	divorced	May 6, 1892	57	1	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Seamstress	Sheppard Pratt Hosp.	Bridgetown, Maryland	

13. FATHER'S NAME: John McMullen

14. MOTHER'S MAIDEN NAME: Martha G. Boyles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT — ADDRESS: Mr. Joseph Clark, 4309 Nicholas Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1yr.

DUE TO

(B) Carcinoma of the breast — 2yr.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-15, 1948 *to* 6-17, 1949 *that I last saw the deceased alive on* 6-16, 1949 *and that death occurred at* 1:00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. Moore M. D.	3105 Belair Rd	6-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	6/20/49	Moreland Park Cemetery	Parkville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JUN 18 1949	Huntington Williams, MD	Wm. Cook, Inc., 1217 St. Paul Street

VS 150

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G75421

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153

Registered No. G75421

1. NAME OF DECEASED (Type or Print): Laura V. Waldman

2. DATE OF DEATH: 15 June 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 803 N. Broadway

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 803 N. Broadway 1405

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 2 Jan. 1873
9. AGE (If over 1 year, last birthday): 76 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore - Md
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Amos Waldman
14. MOTHER'S MAIDEN NAME: Laura

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Wm. L. Gilbert — 1300 Eutaw Place — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Colon with
DUE TO Metastasis
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2yrs -

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1949, to June 15, 1949 that I last saw the deceased alive on June 15, 1949, and that death occurred at 8 A m., from the causes and on the date stated above.

23A. SIGNATURE: Thomas L. Wardley Jr., M. D.
23B. ADDRESS: 2900 Alameda Blvd.
23C. DATE SIGNED: 6/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 18 June 49
24C. NAME OF CEMETERY OR CREMATORY: Pinewood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: F. B. Shubert & Son
ADDRESS: 46E 1300 Eutaw Pl. 17

VS 150

G75422

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ X 7625

G75422

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Thompson.

2. DATE OF DEATH: 6/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Halethorpe
D. STREET ADDRESS (If rural, give location): 1915 Halethorpe Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year, last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
F.	W.		6/16/49				2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: Carl F. Thompson

14. MOTHER'S MAIDEN NAME: Starling Cooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		✓	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxia neonatorum
DUE TO
(B) Premature separation of placenta. — 8 hrs.
DUE TO
(C)

ANTECEDENT CAUSES

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Prematurity 2 lbs

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
F. H. Sherman M. D.	St Agnes' Hosp.	6-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 18, 1949	St. Johns Cem.	Ellicott City, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 18 1949	Huntington Williams, M.D.	Easton Sons Catonsville Md

VS 150

160c

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G75423

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

7-544 G75423 Registered No.

BIRTH NO. B.C. H-6226

1. NAME OF DECEASED (Type or Print): David J. Horsey

2. DATE OF DEATH: JUN 16 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Halstead - 3
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - Essex
D. STREET ADDRESS (If rural, give location): 1722 Glen Curtis Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 11-14-46
9. AGE (In years last birthday): 2 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Dewey J. Horsey
14. MOTHER'S MAIDEN NAME: Mildred Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital heart disease
DUE TO Pulmonary ~~stenosis~~ atresia
(B)
DUE TO
(C)

II
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-11- 1949 to 6-16- 1949 that I last saw the deceased alive on 6-16- 1949 and that death occurred at 12.40 A m., from the causes and on the date stated above.

23A. SIGNATURE: John M. Burnett M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/18/49
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart
24D. LOCATION (City, town, or county) (State): Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John B. Connelly
ADDRESS: 418 Eastern Ave. Balto-21

VS 150

157E

075429

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

075424 Registered No.

1. NAME OF DECEASED (Type or Print): FRANK SOKE

2. DATE OF DEATH: June 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes' Hospital

c. Length of stay in Baltimore: 1 Yrs. 15 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coraopolis
D. STREET ADDRESS (If rural, give location): Box 601 - RD 3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	5-27-1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contracting Work	—	Hungary	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Alex Soke (Decd)	Unknown - (Decd)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) arteriosclerotic
DUE TO C-V Disease -
(B) Cardiac Failure -
(C) Cachexia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gangrenous dysfunction of lower extremities.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/11/49	Amputation of Leg - Gangrene	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from April 28, 1949, to June 12, 1949, that I last saw the deceased alive on June 12, 1949, and that death occurred at 12 noon, from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas Kerbinger M. D.	St Agnes Hospital	6/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	June 18/49	Holy Cross A&A Co	Relative Highway

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 18 1949	Tuttington Williams, MD	Fred A. Kramer & Son	931

VS 150

G75425

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75425

1. NAME OF DECEASED (Type or Print) Maryanna Malinowski

2. DATE OF DEATH 6/16/49

3. PLACE OF DEATH: Baltimore City, Maryland Baltimore

A. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 602 S. ANN St.

B. Length of stay in Baltimore 65 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md.

D. STREET ADDRESS (If rural, give location) 602 S. Ann Street

5. SEX F.

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH 24/12/78

9. AGE (In years last birthday) 69 70 (If under 1 year: Months, Days) (If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Wroblewski

14. MOTHER'S MAIDEN NAME Maryanna Wroblewski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Disease

DUE TO

(B)

DUE TO

(C) Acute Cardiac Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 16, 1949 *to* June 16, 1949, *that I last saw the deceased alive on* June 16, 1949, *and that death occurred at* 7:20 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Andrew J. Stanowski M. D.

23B. ADDRESS 3711 Eastern Ave

23C. DATE SIGNED June 16 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6/21/49

24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 18 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR J. Brzezinski

ADDRESS 407 Eastern Ave

VS 150

93D

G75426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

023

G75426 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henry Scott

2. DATE OF DEATH: June 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Col 12 - Med

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 213 Penn St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Single	5-18-04	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
undertaker		Md	

13. FATHER'S NAME: Ernest Scott

14. MOTHER'S MAIDEN NAME: Lillie Carroll

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-07-1004

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Probable luetic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years.

DUE TO

(B) Aortic Insufficiency. — years.

DUE TO

(C) syphilitic aortitis — years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-14-, 1949, *to* 6-17-, 1949, *that I last saw the deceased alive on* 6-17-, 1949 *and that death occurred at* 11:25 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Anthony J. Dyso M. D.	JOHNS HOPKINS HOSPITAL	6-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	6-21-49	Arlington Mem. Park	Baltimore Co.	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 18 1949	Huntington Williams, M.D.	Frances A. Hensley	578 W. Biddle St

VS 150

20D

G75427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75427

Registered No. 3698

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joshua Barnes

2. DATE OF DEATH June 16, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 616 N. Fulton Ave

C. Length of stay in Baltimore — Yrs. 10 years — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 616 N. Fulton Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	We.	Widowed	Oct. 16, 1869	79 80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown	Unknown	Virginia	U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Irene Winkler	616 N. Fulton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 7 years
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus — Unknown

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-1-, 1942 *to* 6-17-, 1949 *that I last saw the deceased alive on* 6-16-, 1949, *and that death occurred at* 12:30 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank A. Saunders M.D.	1029 N. Stricker St	6-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 20, 1949	Sharon	Baskerville, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 18 1949	Huntington Williams, MD	Charles H. Alexander	1200 McCulloh St.

VS 150

61

GM. 129597

G75428

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75428

1. NAME OF DECEASED (Type or Print) George Choate

2. DATE OF DEATH 6-14-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore 31 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore MD.
D. STREET ADDRESS (If rural, give location) 1702 McCulloh ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Divorced	July 3 1913	35 Yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		N.C.	

13. FATHER'S NAME: Floyd Choate

14. MOTHER'S MAIDEN NAME: Cora Hamilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: B.C.H. Records ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis With Hemhorrage
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 Yrs.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6- 12- , 1949 *to* 6- 14- , 1949, *that I last saw the deceased alive on* 6- 14- 1949, *and that death occurred at* 9.50 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE M. D. | 23B. ADDRESS B.C.H. 4940 Eastern Ave. | 23C. DATE SIGNED 6-14- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/18/49	Fairview R. M. E.	Forest Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Chas. H. Corpew ADDRESS: 512 Canvalus

VS 150

13B

G75429
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157 G75429
Registered No.

1. NAME OF DECEASED (Type or Print): GRACE B. KADDEN

2. DATE OF DEATH: June 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1401 Poplar Grove St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1401 Poplar Grove St. 16-07

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Jan. 31, 1880
9. AGE (In years last birthday): 69 yrs. If Under 1 Year: Months / Days. If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fairmount, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William E. Ford
14. MOTHER'S MAIDEN NAME: Milcah Muir

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mr. Emanuel Eckenrode
ADDRESS: 1401 Poplar Grove St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma Pancreas
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/4, 1949 *to* 6/16, 1949 *that I last saw the deceased alive on* 6/15, 1949, *and that death occurred at* 10A *m., from the causes and on the date stated above.*

23A. SIGNATURE: D. J. Battaglia M. D.
23B. ADDRESS: 5829 Belair Rd
23C. DATE SIGNED: 6/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/20/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, Mo
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

469

G75430

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75430

Registered No.

1. NAME OF DECEASED (Type or Print) Alice Belk Biggs

2. DATE OF DEATH June 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

c. Length of stay in Baltimore 20 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 508 West Franklin St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married	1-19-87	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife		Maryland	

13. FATHER'S NAME: Alexander Worley

14. MOTHER'S MAIDEN NAME: Tanna E. Hopkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-	-	Mr. E. B. Biggs	Millersville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation — Interval between onset and death: 1-2 yrs

DUE TO (B) Calcific aortic & mitral valvulitis — 10-20 years

DUE TO (C) Arteriosclerotic cardiovascular disease — 10-20 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Secondary bronchopneumonia Peptic ulcer of lesser curvature ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	-	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 6-16-49, 1949, *to* 6-17, 1949, *that I last saw the deceased alive on* 6-16, 1949, *and that death occurred at* 8 10 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Margwerite Louisa Candler M. D.	md. gen'l Hospital	6-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/20/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 18 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

927

G75431

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

G75431

Registered No.

1. NAME OF DECEASED (Type or Print): Mr. George William Neugent, Sr.

2. DATE OF DEATH: 6/17/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2411 Arunah Ave.

16 5

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
male	white	married	April 3, 1885	64 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Agent	Insurance Co.	Baltimore, Md.	

13. FATHER'S NAME: James Neugent

14. MOTHER'S MAIDEN NAME: Susan Dixon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Mrs. Emma B. Neugent	2411 Arunah Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 15, 1949, to June 17, 1949, *that I last saw the deceased alive on* June 17, 1949, *and that death occurred at* 5 AM., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John F. Benson M. D.	Un. Hospital	6/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/20/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 18 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

Rs 150

83a

G75432

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75432

1. NAME OF DECEASED (Type or Print): Roath, Mrs. Edith

2. DATE OF DEATH: June 16th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for Incurables 700 W 40th Street
C. Length of stay in Baltimore: Life (Yrs, Mos, Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 616 Ashburton St. 16-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	December 13th 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	None	Baltimore Maryland	U.S.A.

13. FATHER'S NAME: George Winters

14. MOTHER'S MAIDEN NAME: Annie Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	none	F. N. Well.	Home for Incurables

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO arteriosclerosis (generalized)

(B) Rheumatoid Arthritis — 38 years
DUE TO Deformed Joints

(C) Paralysis of Diaphragm (left) — 3yrs +

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 18, 1946 *to* June 16, 1949 *that I last saw the deceased alive on* June 16, 1949 *and that death occurred at* 9 50 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Grafton Hesperger M. D.	214 Medical Arts Building	June 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/20/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150

94a

G75433

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 100.0 N 893.0

Registered No. G75433

1. NAME OF DECEASED (Type or Print) SALLIE JAMES CULSON

2. DATE OF DEATH June 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1619 W. Lafayette Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1619 W. Lafayette Ave. 16-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow	Sept. 2, 1879	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Virginia	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Fisher	Lucinda Brokenbrough

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Miss Ora Culson	1619 W. Lafayette Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetes — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Bruises and lacerations of the face.

DUE TO

(C) Accidental, Fall Down Cellar Stairway

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
Earl L. Kay, M.D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
accident	At Home	1619 W Lafayette Ave Baltimore 16

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
May 11 1949 9 A m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Fall Down Cellar Stairway

22. *I hereby certify that I attended the deceased from* Jan 7, 1949 *to* June 16, 1949, *that I last saw the deceased alive on* June 15, 1949, *and that death occurred at* 6A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. Woodbridge M. D.	Elkridge 27 Md	June 17 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	6-19-49	Mt. Auburn Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 18 1949	Huntington Williams, M.D.	Mrs. Frances A. Hemsley	578 W. Biddle St.

VS 150

186a

To be approved by ✓ Medical Exam.

075434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 075434

BIRTH NO. B.C. 49-16726

1. NAME OF DECEASED (Type or Print) Mildred Dieneti Hardy

2. DATE OF DEATH 6-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 905 Burgundy St.

c. Length of stay in Baltimore 11 Years Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-01
D. STREET ADDRESS (If rural, give location) 905 Burgundy St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	single	Aug 5, 1948		10	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Unit. Hosp. Balto. Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Bernard Hardy

14. MOTHER'S MAIDEN NAME Mary Margaret Mieler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mary Margaret Mieler (Mother) ADDRESS 905 Burgundy St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diffuse Bilateral Atelectasis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Bronchitis, Acute

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
for W. Gallagher
Per Earl L Poyer
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 17, 1949, *to* June 17, 1949 *that I last saw the deceased alive on* June 17, 1949, *and that death occurred at* 6 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Joseph F Riria M. D. 23B. ADDRESS Mercy Hospital 23C. DATE SIGNED 6/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 6/20/49 24C. NAME OF CEMETERY OR CREMATORY Mt Olivet 24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 18 1949 REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1215 Pine St

VS 150

106a

BIRTH NO. 675435 GM 85915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 675435

1. NAME OF DECEASED (Type or Print): Robert L. Leitch

2. DATE OF DEATH: 6- 16- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 106 S. Addison ST, 1904

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov, 29- 1863
9. AGE (In years last birthday): 85
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY:

13. FATHER'S NAME: Leonard
14. MOTHER'S MAIDEN NAME: Mary Harrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records B.C.H. ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO Arteriosclerotic Heart Disease
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Fractured Hip - Right — 16 Days

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
FOR: Dr. C. J. LUBINSKI
PER: [signature] M. D.
(Chief or Asst. Medical Examiner)

19A. DATE OF OPERATION: Yes 6-16-1949
19B. MAJOR FINDINGS OF OPERATION: Fractured Rt Hip - Smith Peterson Nail Inserted
20. AUTOPSY? Yes ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Infirmary
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): B.C.H. Infirmary
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): May 31 -1949 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Fell (Slipped and fell to floor)

22. *I hereby certify that I attended the deceased from* 1- 10- , 194 , *to* 6- 16- , 1949 , *that I last saw the deceased alive on* 6- 16- 1949 , *and that death occurred at* 5.30 Am *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave
23C. DATE SIGNED: 6-16-1949

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial
24B. DATE: 6/18/49
24C. NAME OF CEMETERY OR ~~CREMATORY~~: St. Peters
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc ADDRESS: 217 St. Paul St.

VS 150

To Be Approved by the Chief Medical Examiner

186a

#044684

G75436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

754 G75436 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Richard Marsh

2. DATE OF DEATH JUN 18 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland N. Broadway

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 2 mo 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE N. J. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Maywood,
D. STREET ADDRESS (If rural, give location) 101 Maybrook Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Male	white	Single	7-26-38	10				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	at School	N. J.	

13. FATHER'S NAME Frank Marsh

14. MOTHER'S MAIDEN NAME Wilma Loader

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	None	None

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)

(A) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

DUE TO (B) Subacute Bacterial Endocarditis (Staph Aureus) — 2 mo

DUE TO (C) Tetralogy of Fallot Blalock Taussig Operation — 10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
3/27/49	Tetralogy of Fallot	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-25- *, 19*49 *to* 6-18- *, 19*49 *that I last saw the deceased alive on* 6-18- *19*49 *and that death occurred at* 1:35 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard S Ross	JOHNS HOPKINS HOSPITAL	6/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	6/18/49		Newark N.J.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 19 1949 VS 150	Huntington Williams, M.D.	Geo. L. Berger Jr	5th Howard St

157E

G75437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

581 o G75437 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Howard F. Smith

2. DATE OF DEATH: June 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 927 Leadenhall 23-01

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 43 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Truck Horses

11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ned Smith
14. MOTHER'S MAIDEN NAME: Frances Pitts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-01-3770
17. INFORMANT: Agnes Mason ADDRESS: 243 W Read St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis of liver

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Ruptured esophageal varices DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: William J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: June 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: 6/19-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cemtry
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JUN 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Walter R. Songjo ADDRESS: 139 W Lemmon St

VS 151

124 D V

G75438 154 G75438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BESSIE SALZMAN

2. DATE OF DEATH: 6-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai

C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-27
D. STREET ADDRESS (If rural, give location): 2331 Eutaw Place

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 65 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob
14. MOTHER'S MAIDEN NAME: Etta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Charles Salzman ADDRESS: 2331 Eutaw Pl

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis

DUE TO

(B) Recurrent adenocarcinoma of the head of the pancreas (ovary)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-6 1949 to 6-18 1949 that I last saw the deceased alive on 6-18 1949 and that death occurred at 7 H m., from the causes and on the date stated above.

23A. SIGNATURE: Judith Sinai M. D.
23B. ADDRESS: Sinai Hospital Baltimore Md
23C. DATE SIGNED: 6-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-19-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Rewers Inc ADDRESS: 2100 Eutaw Pl

469

G75439

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

17° G75439

Registered No.

1. NAME OF DECEASED (Type or Print) Mrs. Rebecca Norwitz

2. DATE OF DEATH 6-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Levindale

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1716 E Fayette St

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH
9. AGE (In years last birthday) 57
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Israel Lipsy
14. MOTHER'S MAIDEN NAME Jennie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Isadore Norwitz ADDRESS 1716 E Fayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast

DUE TO with osseous metastases

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-16, 1949, *to* 6-18, 1949, *that I last saw the deceased alive on* 6-18, 1949, *and that death occurred at* 4:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Jerome J. Blumberg M. D.
23B. ADDRESS Levindale Home
23C. DATE SIGNED 6-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6-20-49
24C. NAME OF CEMETERY OR CREMATORY Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State) Gatto Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Jr
ADDRESS 2100 Eutaw Pl

50

G75440

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75440 #3

1. NAME OF DECEASED (Type or Print): Samuel Chipman

2. DATE OF DEATH: 6-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levendale
C. Length of stay in Baltimore: 50 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-47
D. STREET ADDRESS (If rural, give location): 2329 Braddish Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married		75				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant	Burlap Bags	Russia	

13. FATHER'S NAME: Nathan

14. MOTHER'S MAIDEN NAME: Edith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Helen Chipman ADDRESS: 2329 Braddish Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary sclerosis

DUE TO General arteriosclerosis

= Cerebral arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

State after left sided hemiplegia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-3, 1949, *to* 6-18, 1949, *that I last saw the deceased alive on* 6-18, 1949, *and that death occurred at* 5:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jerome J. Blumberg M. D.	Levindale Home	6-18-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-19-49	Mishkon Israel	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 19 1949	Huntington Williams, MD	Jack Lewis & Co	2100 Eutaw Pl

VS 150

94a

G75441

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4/20 | G75441 Registered No.

1. NAME OF DECEASED (Type or Print): Theresa Corasaniti

2. DATE OF DEATH: 6-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 130 N. Kenwood Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 130 N. Kenwood Ave 6-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Feb. 2, 1862	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housefe		ITALY	

13. FATHER'S NAME: Paul Ranieri

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Anthony Corasaniti ADDRESS: 2454 Pennington Ave Elkton Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Interval between onset and death: 1 hour

DUE TO

(B) Arteriosclerotic C.V. disease — 5 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/15/49, 19__, *to* 6/17/49, 19__, *that I last saw the deceased alive on* 6/17/, 19 49, *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bessie B. Moses M.D.	448 N. Luzerne Ave	6/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/20/49	Holy Redeemer Cem	Belair Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 19 1949	Evington Williams, M.D.	John C. Nolan	3000 E. Baltimore St

VS 150

937

G75442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

581.0

G75442 47

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Parker, Obediah

2. DATE OF DEATH: 6-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 715 N. Fulton Avenue

16-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	M	2-17-02	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Obediah Parker

14. MOTHER'S MAIDEN NAME: Maggie West

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT / ADDRESS: Willie Mae Parker (wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of liver

DUE TO

(B) Hepatic insufficiency

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 5-16

19B. MAJOR FINDINGS OF OPERATION: Cirrhosis of liver

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., Home, about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23A. SIGNATURE: J. F. Hawkins Jr. M. D.

23B. ADDRESS: Franklin Sq. Hosp.

23C. DATE SIGNED: 6/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: June 19/49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemt

24D. LOCATION (City, town, or county) (State): B. A. C. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 19 1949

REGISTRAR'S SIGNATURE: Thomas Livingston Williams, M.D.

25. FUNERAL DIRECTOR: Isaiah L. Brown Son

ADDRESS: 108 W Montgomery St

VS 150

124B

BIRTH NO. G75443

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75443

1. NAME OF DECEASED (Type or Print): Anna S. Mc Mahon

2. DATE OF DEATH: 6-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3222 Steickland ST

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20 06
D. STREET ADDRESS (If rural, give location): 3222 Steickland ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	married	Nov. 12, 1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Baltimore	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Patrick Murphy	Margaret Cullen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Philip P.J. Mc Mahon	3222 Steickland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Thrombosis	1 day
DUE TO (B)	Cardio Vascular Disease	2 Years
DUE TO (C)	Osteoarthritis	6 Years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Elliot Wyckoff M. D.	3432 Frederick Ave	6/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-20-49	Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 19 1949	Thurston Tom Williams, M.D.	George A. Farley	Fulton Ave + Fayette St.

937

G75447 G75447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4/16

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sister Mary Magdalen Bond

2. DATE OF DEATH 6/17/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balt. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-01

c. Length of stay in Baltimore 2 mths 11 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2025 W. Fayette St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F.	W	S	11/19/96	52				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME Benj. F. Bond

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mother Mary Bon Secours Hosp. ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic cardio-vascular disease with cardiac decompensation. Contributing factor is embolism.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Multiple embolisms.

INTERVAL BETWEEN ONSET AND DEATH 36 yrs.

19A. DATE OF OPERATION None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 6, 1949, to June 17, 1949, *that I last saw the deceased alive on* June 16, 1949, *and that death occurred at* 7 15 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE Walter B Sanger M. D.

23B. ADDRESS Bon Secours Hospital

23C. DATE SIGNED June 17 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6-20-49

24C. NAME OF CEMETERY OR CREMATORY Cathedral Cem.

24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR 6-19-49

REGISTRAR'S SIGNATURE Thos. Fox Williams, M.D.

25. FUNERAL DIRECTOR George A. Tully ADDRESS Fulton and Fayette Sts.

VS-150

93C

BIRTH NO. G75445

BALTIMORE CITY. HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75445

1. NAME OF DECEASED (Type or Print): Mary E. Fritz

2. DATE OF DEATH: 6-16-49

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West. Baltimore General Hosp.

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-02
D. STREET ADDRESS (If rural, give location): 401 E. Cross St #30

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	12-18-05	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife.		Maryland	USA.

13. FATHER'S NAME: Isaac Dixon

14. MOTHER'S MAIDEN NAME: Emma Lowry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			John C. Fritz	401 E. Cross St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation

DUE TO

(B) Aortic Stenosis & Septal defect

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-13-49, 19__, *to* 6-16-49, 19__, *that I last saw the deceased alive on* 6-16-49 19__, *and that death occurred at* 6:35 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bowie Lynn Grant MD. M. D.	West. Baltimore Gen. Hosp	6-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
BURIAL	6-20-1949	CEDAR HILL	BROOKLYN MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 19 1949	Thurston Williams, M.D.	G. Howard Strong	3207 W. North Ave

VS 150

920

G75446 BALTIMORE CITY HEALTH DEPARTMENT G75446

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) Melvin Albert Spellman — 2. DATE OF DEATH June 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3114 Presbury St.,

c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 3114 Presbury St., 15-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Divorced	Jan. 15, 1911	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Accountant		Md.	

13. FATHER'S NAME: Charles A. Spellman

14. MOTHER'S MAIDEN NAME: Reina Thalheimer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. Chas. A. Spellman	3114 Presbury St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH. (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 16, 1949, to June 17, 1949, *that I last saw the deceased alive on* June 17, 1949 *and that death occurred at* 7.45 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Elliott M. Kleban, M. D.	1735 Poplar Gr. St.	6/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-20-49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 19 1949		G. Howard Strong	3207 W. North Ave.

VS 150

Huntington Williams, M.D.

94a

BIRTH NO. G75447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75447.

1. NAME OF DECEASED (Type or Print): James Jr Keating

2. DATE OF DEATH: 6-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: About 1 month (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS, (If rural, give location): 415 Railroad Ave.

5. SEX: M
6. COLOR OR RACE: B
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 3-10th 1915
9. AGE (In years last birthday): 34 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Morris Keating
14. MOTHER'S MAIDEN NAME: Addie Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unk.
16. SOCIAL SECURITY NO.: 218-01-4213
17. INFORMANT: Queen Ramsgold ADDRESS: 415 Railroad Ave Towson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) atelectasis, left c
DUE TO pneumonitis
(B) Encephalitis, suspected
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Wasserman positive

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-1- , 1949 to 6-16- , 1949 *that I last saw the deceased alive on* 6/15/ , 1949 *and that death occurred at* 1:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Rosser M. D.
23B. ADDRESS: University Hospital, Balto
23C. DATE SIGNED: 6-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-19th 1949
24C. NAME OF CEMETERY OR CREMATORY: Pleasant Rest Cem.
24D. LOCATION (City, town, or county) (State): Towson Balto Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 16 1949
REGISTRAR'S SIGNATURE: Hunting for Williams, MD
25. FUNERAL DIRECTOR: Bafsom Francis Knight ADDRESS: 721 Ausgusta St. Balto 2 Md

309

G75448

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

470-1 G75448 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Louise T. Abell

2. DATE OF DEATH June 17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 208 N. Collington Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 208 N Collington Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE In years last birthday	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Female	White	Widowed	Dec 20 1873	75 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Balto. Md.	

13. FATHER'S NAME Silvis Bourgies

14. MOTHER'S MAIDEN NAME Mary Krebs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Catherine Lockhart ADDRESS 982 Hamilton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B) Arteriosclerosis & Hypertension — 4 Y.
DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 2nd, 1945 *to* 4/14th, 1949, *that I last saw the deceased alive on* 4/14th, 1949, *and that death occurred at* 7:35 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. L. Lankin M. D.	1004 Mulberry	6/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-20-49	New Cathedral	Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 1 9 1949	Evington Williams, M.D.	John C. Miller Inc.	2435 E. Oliver St

VS 150

94a

G75449

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75449

1. NAME OF DECEASED (Type or Print) Frank B. Seibold

2. DATE OF DEATH 6/18/49

3. PLACE OF DEATH: a. Baltimore City, Maryland 3027 Clifton Ave

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3027 Clifton Ave 15-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year Months	Days	If under 24 hours Hours	Min.
Male	White	Widowed	June 22, 1857	92				

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Freight Claim Dept	Steamships	Baltimore	U.S.A.

13. FATHER'S NAME Michael Seibold

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	212-14-3391	Mrs. A. W. Best	4304 Belvieu Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease ?
DUE TO Mitral Stenosis, Insufficiency ?
(B) Generalized Arteriosclerosis ?
DUE TO
(C) Senility

INTERVAL BETWEEN ONSET AND DEATH: A.C. 92

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 1948 *to* June 18, 1949 *that I last saw the deceased alive on* 6-18-1949 *and that death occurred at* 10.06 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert H. Kline M. D.	Cal. & 30th St. Balto. 18.	6-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/21/49	Greenmount	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	[illegible]	Loring Byers	5005 Pk Heights Ave

VS 150

92 B

G75450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75450

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harry C. Webster Sr.

2. DATE OF DEATH June 18, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland 3916 Hayward Ave

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE 3916 Hayward Ave
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 3916 Hayward Ave 27-18

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	M.	Dec. 22, 1862	86 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired (Owner)	Poultry Business	Balto.	U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS
Mrs. Henry C. Webster Jr. 3916 Hayward Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio - sclerosis

DUE TO resulting in great cerebral hemorrhage

(B) produced by ordinary obstruction

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: Many yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 6/14, 1949 to 6/17, 1949, that I last saw the deceased alive on 6/16, 1949, and that death occurred at 11:P m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry C. Webster M. D.	3902 Greenlawn Ave	6/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	6/20/49	Druid Ridge	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS
Loring Byers 5005 K Wyoming

VS 150

94a

3251

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G75451

44 Registered No.

1. NAME OF DECEASED (Type or Print) Frank D. Siebring

2. DATE OF DEATH June 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 4615 Kirwan Blvd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Haven Nursing Home

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-04
D. STREET ADDRESS (If rural, give location) 1937 Guilford Ave.

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) Married

8. DATE OF BIRTH Nov 11 1865 | 9. AGE (In years last birthday) 83 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer & Publisher | 10B. KIND OF BUSINESS OR INDUSTRY Newspaper

11. BIRTHPLACE (State or foreign country) Hartford Wis. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frederick Siebring

14. MOTHER'S MAIDEN NAME Unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No. | (If yes, give war or dates of service) — | 16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. W. B. Rowans | ADDRESS 1929 Bridge Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 2+ hrs

DUE TO

(B) Essential hypertension — 6 mos.

DUE TO

(C) Arteriosclerosis — 4 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 21, 1949, to June 19, 1949, *that I last saw the deceased alive on* June 17, 1949, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Benjamin D. Siegel M.D. | 23B. ADDRESS 15 Fremwood Rd Pikesville, Md | 23C. DATE SIGNED 6/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 24B. DATE June 20/49 | 24C. NAME OF CEMETERY OR CREMATORY Greenmount Park Co. | 24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Loring Byers | ADDRESS 5005 Park Heights Ave

VS 150

97

G75452

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

151 G75452 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE D. DEWS

2. DATE OF DEATH June 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3000 W. Cold Spring La

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 50 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3000 W. Cold Spring Lane 15-15

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 11, 1879
9. AGE (In years last birthday) 70 — If under 1 year: Months 3 Days 5 — If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist
10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel

11. BIRTHPLACE (State or foreign country) Marietta, Ga.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry W. Dews

14. MOTHER'S MAIDEN NAME Lila Trentham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-05-5362

17. INFORMANT Mrs. Lena A. Dews ADDRESS 3000 W. Cold Sprin

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Stomach — Unknown
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION Feb 24, 1949
19B. MAJOR FINDINGS OF OPERATION Carcinoma of Stomach
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 19 49 *to* June 17, 19 49, *that I last saw the deceased alive on* June 17, 19 49 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE Dr Harry Cohman M. D.
23B. ADDRESS 1921 W Lorth Ave
23C. DATE SIGNED 6-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 20, 1949
24C. NAME OF CEMETERY OR CREMATORY Western
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR William Cook, Inc. ADDRESS 1217 St. Paul Street

46B

75453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 1

Registered No. 4-40-0 GZ54547

1. NAME OF DECEASED (Type or Print): Mary Annie Helen Hilde

2. DATE OF DEATH: June 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1005 Argyle Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1005 Argyle Avenue

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. If under 1 year: Months, Days. If under 24 hours: Hours, Min.)
F	C	M	11/22/1896	52

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore Md.	U.S.A.

13. FATHER'S NAME: John Barber

14. MOTHER'S MAIDEN NAME: Eleanore Bankens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No		J. Chandler	1005 Argyle Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Arterio-sclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Asthma

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1947 *to* June, 1949, *that I last saw the deceased alive on* 6-14, 1949 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ronald B. Lighthelm M. D.	501 Cherry Hill Road	6-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-20-49	New Cathedral	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, MD	Mrs Katie R. Williams	322 N Wheeler St

VS 150

937

AB-129073
75454
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 G75454
Registered No.

1. NAME OF DECEASED (Type or Print) Edward Austin

2. DATE OF DEATH 6-15-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore — Yrs. — Mos. — Dys.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 869 Boyd Street 18-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Negro	Married	Aug. 5- 1890	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Walter Austin
14. MOTHER'S MAIDEN NAME Lilly Bunford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Records- ADDRESS Baltimore City Hospitals 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac failure
DUE TO
(B) Arteriosclerotic hypertensive cardiovascular disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES XX NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-18- , 1949, *to* 6-15- , 1949, *that I last saw the deceased alive on* 6-15- , 1949, *and that death occurred at* 12.57 PM *from the causes and on the date stated above.*

23A. SIGNATURE C. S. Rogers M. D.
23B. ADDRESS Baltimore City Hospitals
23C. DATE SIGNED June 16-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-20,1949	Arbutus Memorial	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR Mrs Katie R. Williams
ADDRESS 322 N Schroeder St

VS 150

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G75455

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1 G75455

Registered No.

1. NAME OF DECEASED (Type or Print): ETHEL HENSON

2. DATE OF DEATH: June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1135 Sarah Ann St. 18-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C		Dec. 22, 1900	48				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland.	U.S.A.

13. FATHER'S NAME: Edward Francy.

14. MOTHER'S MAIDEN NAME: Elizabeth Griffin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Louis J. Hevner ADDRESS: 1135 Sarah Ann St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 7

DUE TO

(B) Hypertension (C.V.D.) — 5 Yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 15, 1949 *to* June 15, 1949, *that I last saw the deceased alive on* June 15, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph Shear M. D.	Univ. Hospital	June 16, 1949

24A. BURIAL, CREMATION OR REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-20-1949	Mt. Auburn	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	Mrs Katie R. Williams	322 N Schroeder St

VS 150

93D

75456
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3 31 G75456
Registered No.

1. NAME OF DECEASED (Type or Print) Geneva Green

2. DATE OF DEATH 6/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 121 Welcome al

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

C. Length of stay in Baltimore 20 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE
121 Welcome al
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balto - xx-01
D. STREET ADDRESS (If rural, give location)
121 Welcome al

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Single	1895	54 yrs	-			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	none	Florence, S. C.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
unknown	unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	no		Lula Saunders	121 Welcome al

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebr al Hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

DUE TO

(B) Hypertension nephritis,

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/1, 1949 *to* 6/17, 1949 *that I last saw the deceased alive on* 6/16, 1949, *and that death occurred at* 9a, *m. from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
[illegible]	Irvington	6/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/21/49	Mt. Calvary	a. a. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Twilington Williams, M.D.	James A. Mayo	142 W. Nile

VS 150

131a

5457
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E981-5
Registered No. 075457

1. NAME OF DECEASED (Type or Print): Henry Vernal Barefoot N-861-F

2. DATE OF DEATH: June 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 547 Laurens St. 14-D

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 21, 1927
9. AGE (In years last birthday): 21
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wilson, N. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Lenwood Barefoot
14. MOTHER'S MAIDEN NAME: Bertha Moore
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Lenwood Barefoot ADDRESS: 547 Laurens St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bullet Wound of Heart
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Laurens near Pennsylvania Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 17, 1949 ? P. m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Firearms 14/2

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: June 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-21-49
24C. NAME OF CEMETERY OR CREMATORY: Arlington Mem.
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 20 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: Mr. Francis A. Hemsley Bittle
ADDRESS: 578 W

VS 151

166

75458

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 G75458

Registered No.

1. NAME OF DECEASED (Type or Print) James F.Andrysiak (Anderson)

2. DATE OF DEATH 6/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 611 S.Belnord Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24,
D. STREET ADDRESS (If rural, give location) 611 South Belnord Ave

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 10/29/90

9. AGE (In years last birthday) 58 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer

10B. KIND OF BUSINESS OR INDUSTRY transfer Co.

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Andrysiak

14. MOTHER'S MAIDEN NAME Mary Nowak

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-07-8589

17. INFORMANT ADDRESS Mrs.Ida Andrysiak 611 S.Belnord Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH: 18 mos.

DUE TO

(B)

DUE TO

(C) Myocardial Insufficiency

II
ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION June 1948

19B. MAJOR FINDINGS OF OPERATION Carcinoma, Metastatic Gland Removed

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 10, 19 48, *to* June 17, 19 49, *that I last saw the deceased alive on* ____, 19 ____, *and that death occurred at* ____ m. *from the causes and on the date stated above.*

23A. SIGNATURE John G. Schenuit M. D.

23B. ADDRESS 1337 S. Charles St.

23C. DATE SIGNED 6/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6/21/49

24C. NAME OF CEMETERY OR CREMATORY St.Stanislaus

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949

VS 150

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS George A.Weber 705 South Ann Street

47D

G75459

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75459

1. NAME OF DECEASED (Type or Print) FRANCE, TODD

2. DATE OF DEATH June 19 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Marburg

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md — B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) Warrington Apt 12-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	10-5-70	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frank Gardiner

14. MOTHER'S MAIDEN NAME Frances ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 5 yrs.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. asthma, Bronchial — 30+ yr.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* 6/6 19 49 *to* 6/19 19 49 *that I last saw the deceased alive on* 6/19 19 49 *and that death occurred at* 11:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE Wardell B. Carlson M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED 6-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE June 20/49

24C. NAME OF CEMETERY OR CREMATORY St Thomas'

24D. LOCATION (City, town, or county) (State) Garrison Forest Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Harry W Jenkins & Sons Co

ADDRESS 4905 Yorktd 93D

VS-150

75460

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 ✓ Registered No. G75460

1. NAME OF DECEASED (Type or Print) **Francis P. McClean**

2. DATE OF DEATH **June 18, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Crawford Retreat 2117 Denison Street**

C. Length of stay in Baltimore: Yrs. **Life** Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **139 E. North Ave.** 12.05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	July 23, 1879	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Foundry	Baltimore, Md.	

13. FATHER'S NAME **Charles McClean**

14. MOTHER'S MAIDEN NAME **Rose O'Hara**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Francis P. McClean	139 E. North Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Embolism

DUE TO Myocarditis

(B) Arteriosclerosis

DUE TO Benign Prostatic Hypertrophy.

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hernia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 2 19 49, to June 18, 19 49, *that I last saw the deceased alive on* June 18, 19 49, *and that death occurred at* 6:40 m., *from the causes and on the date stated above.*

23A. SIGNATURE Nathan E. Reedle M. D. | 23B. ADDRESS 3314 - St. Nora Ave | 23C. DATE SIGNED 6/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/21/49	Cathedral	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	H.W. Mears and Son.	805 N. Calvert St

VS 150

93D

75461 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

53 ✓ G75461 Registered No.

1. NAME OF DECEASED (Type or Print) Joseph Lyons

2. DATE OF DEATH June 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore 5 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3807 Fern ave. 58-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	married	8-18-08	40				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Seaman		Ga.	

13. FATHER'S NAME Joseph Lyons

14. MOTHER'S MAIDEN NAME Beatrice Cuidgon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ADENOCARCINOMA, RT. CEREBELLAR HEMISPHERE METASTATIC — INTERVAL BETWEEN ONSET AND DEATH: 1 MONTH

DUE TO

(B) ADENOCARCINOMA OF SIGMOID 6 MONTHS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
JUNE 16, 1949	ADENOCARCINOMA, RT CEREBELLAR HEMISPHERE	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 6-15, 1949 to 6-17, 1949, that I last saw the deceased alive on 6-17, 1949 and that death occurred at 550 P. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert E. Green M. D.	JOHNS HOPKINS HOSPITAL	June 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 21 1949	Soniat Cemetery	New Orleans La.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Evelyn Williams, MD	Harry H. Simmons	4204 Edgewood Ave

VS 150

46E

3462

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

445 G75462

Registered No.

1. NAME OF DECEASED (Type or Print) — NORR, CHARLES Henry

2. DATE OF DEATH — 6/18/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — SINAI

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — SINAI

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — BALTIMORE Md.
D. STREET ADDRESS (If rural, give location) — 741 S CURLEY ST. 1-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	Feb. 17, 1913	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician	Beth. Steel	Baltimore, Md.	

13. FATHER'S NAME — John Norr

14. MOTHER'S MAIDEN NAME — Elsie Foeller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT — ADDRESS — Ruth A. Norr- wife - 741 S. Curley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypocalcemia — INTERVAL BETWEEN ONSET AND DEATH: 1+ days

DUE TO

(B) UREMIA — 7+ days

DUE TO

(C) MALignant Hypertension — 2+ years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/17 *1949 to* 6/18 *, 1949, that I last saw the deceased alive on* 6/18 *1949, and that death occurred at* 1 00 *A.M., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lester Steinberg M. D.	Sinai Hosp.	7/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/21/49	Trinity Cem.	5500 O'Donnell St. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JUN 20 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

102°

75463

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

44 V

Registered No. G75463

1. NAME OF DECEASED (Type or Print) John W. Hamilton

2. DATE OF DEATH June 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 143 N. Lakewood Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Balto. Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md.
D. STREET ADDRESS (If rural, give location) 143 N. Lakewood Ave.

6-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	married	7/16/1878	70	11	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
machinist	Copper Works	Balto. Md.	

13. FATHER'S NAME: Wm. T.

14. MOTHER'S MAIDEN NAME: Laura Engle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	216-03-5892	Wife	143 N. Lakewood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac dilatation — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cardio renal disease

DUE TO

(C) hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY. m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 6, 1949, to June 7, 1949, that I last saw the deceased alive on June 7, 1949, and that death occurred at 8:55 p m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles L. MacMunn M. D.	2911 E. Baltimore St.	June 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	6/20/49	Balto.	North Ave. & Rose St.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	Clarence F. Hoffmann	1639 E. Broadway

VS 150

1310

G75462

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75464

1. NAME OF DECEASED (Type or Print): Alois Bredl

2. DATE OF DEATH: 15 June 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): (DOA) Baltimore City Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Brooklyn Park
B. COUNTY: Balto Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mudale Rural
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	?	65 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Ice House Helper	Austria	

13. FATHER'S NAME: Unk.

14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Holzbauer Ice Co. ADDRESS: Mudale Rural

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY Ooccur?
m.		

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Wm H Kammer Jr. M.D.	☐ / ☐ / ☒	16 June 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/18/49	Sacred Heart	Glen Mill Rd

DATE RECEIVED BY LOCAL REGISTRAR: JUN 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: John L. Connelly ADDRESS: Govans Md

VS 151

94a

75465

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75465

1. NAME OF DECEASED (Type or Print) Maurice C Kirschenbaum

2. DATE OF DEATH June 20, 1949

3. PLACE OF DEATH:
X Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3736 Dolfield Ave

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3736 Dolfield Ave 15-11

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan, 1, 1894
9. AGE (In years last birthday) 55
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrican
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Morris Kirschenbaum
14. MOTHER'S MAIDEN NAME Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Sophie Kirschenbaum ADDRESS 3736 Dolfield Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Minutes
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Angina Pectoris — 1 Months

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day), (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 15, 1949, to June 19, 1949 *that I last saw the deceased alive on* June 18, 1949, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Alvin S. Harte, M. D.
23B. ADDRESS 5743 Park Heights
23C. DATE SIGNED 6/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 21, 1949
24C. NAME OF CEMETERY OR CREMATORY Hebrew Washington Rd Cem
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Sol Levinson & Bros
ADDRESS 1126 W North Ave

VS 150

94a

G75466
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E976.0 G75466
Registered No.

1. NAME OF DECEASED (Type or Print): Col. Harry Cooper — N-853.4
2. DATE OF DEATH: June 17, 1949
3. PLACE OF DEATH: Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   a. STATE: Maryland
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
   d. STREET ADDRESS (If rural, give location): 3401 Pinkney Road — 27-20
   e. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
   f. Length of stay in Baltimore: 8 Yrs (Yrs. Mos. Days)
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 15, 1895
9. AGE (In years last birthday): 54 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired U. S. Army
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Bernard Cooper
14. MOTHER'S MAIDEN NAME: Julia
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Fanny Cooper — ADDRESS: 3401 Pinkney Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bullet wound of Brain
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3401 Pinkney Rd
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): June 17, 1949 9:45 P.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Firearms

22. *I certify that I took charge of the remains described above, held an* Insp. & In. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23a. SIGNATURE: Earl L Royer M.D.
23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23c. DATE SIGNED: June 18, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 21, 1949
24c. NAME OF CEMETERY OR CREMATORY: Arlington Nat Cemetery
24d. LOCATION (City, town, or county) (State): Arlington Va

DATE RECEIVED BY LOCAL REGISTRAR: JUN 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

HV 151

164c

G75467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5410

G75467

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William H. Lindsay

2. DATE OF DEATH June 18-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore Yrs. Life. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3002 Keswick Rd. 13-05

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH June 13-1888 | 9. AGE (In years last birthday) 61 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physicist | 10B. KIND OF BUSINESS OR INDUSTRY Johns Hopkins Univ.

11. BIRTHPLACE (State or foreign country) Baltimore, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME George A. Lindsay

14. MOTHER'S MAIDEN NAME Annie M. Rogers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 216-05-2485

17. INFORMANT Mrs. Esther M. Lindsay | ADDRESS 3002 Keswick Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Gastritis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 6-8-49 | 19B. MAJOR FINDINGS OF OPERATION Duodenal Ulcer | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/13/49, 19__, to 6/18/49, 19__, that I last saw the deceased alive on 6/18/49, 19__, and that death occurred at 5:15 a.m., from the causes and on the date stated above.

23A. SIGNATURE William F. Rienhoff, M. D. | 23B. ADDRESS St. Joseph's Hospital | 23C. DATE SIGNED 6-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE June 21-1949 | 24C. NAME OF CEMETERY OR CREMATORY Meadow Ridge | 24D. LOCATION (City, town, or county) (State) Howard Co. Maryland

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Burgee Funeral Home | ADDRESS 3631 Falls Road

VS 150

1178

75468 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 1949 G75468 Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Nettie Kershaw Garrett

2. DATE OF DEATH: June 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1004 Roland Heights Avenue
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1004 Roland Heights Avenue

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 13, 1870
9. AGE (In years last birthday): 79 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Edwin Kershaw
14. MOTHER'S MAIDEN NAME: Martha McCauley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: ----
17. INFORMANT: George E. Garrett ADDRESS: 1004 Roland Heights Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemhonage — INTERVAL BETWEEN ONSET AND DEATH: 2 hours.
DUE TO
(B) Arteriosclerosis — 10 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 13 1949 *to* June 16, 1949 *that I last saw the deceased alive on* June 16, 1949, *and that death occurred at* 12-30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Arthur J Davis M. D.
23B. ADDRESS: 2001 W 32nd St
23C. DATE SIGNED: 6-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 20, 1949
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JUN 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

VS 150

83a

G75469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75469

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE ALBERT BENSON

2. DATE OF DEATH 6/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSP.

C. Length of stay in Baltimore 87 Yrs. Mos. Days LIFE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 13-16
D. STREET ADDRESS (If rural, give location) 3606 ROLAND AVE

5. SEX MALE
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED
8. DATE OF BIRTH 6/5/62
9. AGE (In years last birthday) 87
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pres. C. F. Benson Sons Inc.
10B. KIND OF BUSINESS OR INDUSTRY Hardware
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JOHN P. BENSON

14. MOTHER'S MAIDEN NAME GORSUCH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-26-3468

17. INFORMANT DR. C.F. BENSON ADDRESS SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	UREMIA	3 WKS
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B)	ARTERIOSCLEROTIC C.V.R. DISEASE	6 MO.
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	PARTIAL INTESTINAL OBSTRUCTION CHRONIC NEPHRITIS	2 WKS

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/13 19 49, *to* 6/17 19 49 *that I last saw the deceased alive on* 6/17 19 49, *and that death occurred at* 10 00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Paul G. Herold M. D.
23B. ADDRESS Maryland General Hosp
23C. DATE SIGNED 6/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 21-1949
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge
24D. LOCATION (City, town, or county) (State) Pikesville Maryland

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR J. Burgee Funeral Home
ADDRESS 3631 Falls Road

VS 150

131a

75470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58-10 G754770 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Cornelius F. Murphy

2. DATE OF DEATH 6/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1210 Washington Blvd

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-04

D. STREET ADDRESS (If rural, give location) 1210 Washington Blvd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M.	W.	Married	7/11/1899	49				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Officer	Police Dept.	Baltimore Md.	U S A

13. FATHER'S NAME John J Murphy

14. MOTHER'S MAIDEN NAME Mary E. Tierney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Stella J. Murphy ADDRESS 1210 Washington Blvd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of the Liver — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Obesity.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 11, 1946 to June 15, 1949, that I last saw the deceased alive on June 18, 1949, and that death occurred at 10:15 m., from the causes and on the date stated above.

23A. SIGNATURE John O. Ulrich, Jr. M. D. — 23B. ADDRESS 1227 Washington Blvd — 23C. DATE SIGNED 6-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE 6/22/49 — 24C. NAME OF CEMETERY OR CREMATORY New Cathedral — 24D. LOCATION (City, town, or county) (State) 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949 — REGISTRAR'S SIGNATURE Huntington Williams, MD — 25. FUNERAL DIRECTOR John J. Cowan & Son — ADDRESS 2901 Hollins St

VS 150

124B

75471

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75471 Registered No.

1. NAME OF DECEASED (Type or Print) EDWARD J. FRENCH — 59

2. DATE OF DEATH JUNE 19 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTO. GEN. HOSP.

C. Length of stay in Baltimore 60 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO.
D. STREET ADDRESS (If rural, give location) 1919 WILKENS AVE. 2-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		AUG 1866	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Shipping Clerk	MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas French	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	DAUGHTER	1919 Wilkens Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH: 1 MO.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B) CARCINOMA - OBSTRUCTIVE JAUNDICE
DUE TO (C) CARCINOMA - HEAD OF PANCREAS? CECUM ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 15 1949 *to* June 17, 1949, *that I last saw the deceased alive on* June 18, 1949, *and that death occurred at* 7:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	W36 St	6/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/23/49	New Cathedral	4300 Old Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	John J. Cowan & Son	901 Hollins St.

VS 150

46E

75472

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

491 Registered No. 75472

1. NAME OF DECEASED (Type or Print) HARRY JONES

2. DATE OF DEATH June 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
1024 East Chase Street 10-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Single	April 28-1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Balto. Md.	

13. FATHER'S NAME
Thomas Jones

14. MOTHER'S MAIDEN NAME
Annie Garland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Sarah J. Reinsfelder	2032 E. Lanvale St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

(B) Broncho pneumonia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
William J. McClafferty M.D.		June 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 20/49	Balto. Cemetery	North Ave. + Gay St.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	John L. Keller	2334 Jefferson St. 937

VS 151

G75473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75478

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sarah Johnson

2. DATE OF DEATH June 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1317 Whatcoat St

c. Length of stay in Baltimore Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1317 Whatcoat St 15 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Divorced	Dec 25 1894	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Balto md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Brown	Carrie Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		James Johnson	1109 N. Parrish St

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: about five weeks

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 8 *to* June 18, 1949, *that I last saw the deceased alive on* June 18 1949, *and that death occurred at* 6 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. Gerald Chiarell, M. D.	1534 David Hill Ave	June 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/21-49	mt auburn.	md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 19	Huntington Williams, M.D.	George E. Nelson	1303 Presstman St

VS 150

94a

75474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75474

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George John Klein

2. DATE OF DEATH June 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Parkville
D. STREET ADDRESS (If rural, give location) 25 Linganore Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	Widowed	Aug 26-1875	73 72	9	25

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY B. T. Pensioner

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Klein

14. MOTHER'S MAIDEN NAME Sophia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Henry D. Klein ADDRESS 4808 Holdes

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage from bladder mucosa — INTERVAL BETWEEN ONSET AND DEATH 12 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular disease

DUE TO

(C) Coronary occlusion

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 11, 1949, *to* June 19, 1949, *that I last saw the deceased alive on* June 19, 1949, *and that death occurred at* 5:40p. m., *from the causes and on the date stated above.*

23A. SIGNATURE A. Andrew Aleese, M. D.

23B. ADDRESS 1400 N. Caroline St.

23C. DATE SIGNED June

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6-23-49

24C. NAME OF CEMETERY OR CREMATORY Baltimore

24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR Leonard J. Luck ADDRESS 5305 Harford

VS 150

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G75475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75475 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDNA B. RAYNES

2. DATE OF DEATH 6-18-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital.

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3112 Darley Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	M	July 4 1903	45 44	9	17

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Oliver Miller
14. MOTHER'S MAIDEN NAME Beulah Landon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO.
17. INFORMANT Alberta H. Raynes-Landon ADDRESS 3112

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Accident.	
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Diabetes Mellitus.	

19A. DATE OF OPERATION 6-13-49.
19B. MAJOR FINDINGS OF OPERATION Subdural Abscess
20. AUTOPSY? YES ☑ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-7-49 *to* 6-18 19 49, *that I last saw the deceased alive on* 6-18 19 49, *and that death occurred at* 5 50 p m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D. H. K. Bruen
23B. ADDRESS Md. Gen Hosp
23C. DATE SIGNED 6-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6-21-49
24C. NAME OF CEMETERY OR CREMATORY Parkwood.
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Leonard J. Buck ADDRESS 5305 Harford

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

STATE FILE NO. 254176 — Registered No. G75476

1. NAME OF DECEASED (Type or Print)	WILFORD F. KLEIN
2. DATE OF DEATH	June 19, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	224 S. Broadway
C. Length of stay in Baltimore	Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	224 S. Broadway 2-07
5. SEX	M
6. COLOR OR RACE	W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	W
8. DATE OF BIRTH	3-8-1869
9. AGE (In years last birthday) / If under 1 year: Months, Days / If under 24 hours: Hours, Min.	80 89
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Retired
10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)	Balto., Md.
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	John Klein
14. MOTHER'S MAIDEN NAME	Elizabeth ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	
17. INFORMANT / ADDRESS	Mrs. Ethel M. Bauer, 5400 Catalpha

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED June 20, 1949
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-22-49	24C. NAME OF CEMETERY OR CREMATORY Parkwood
		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR / ADDRESS Leonard J. Ruck, 5305 Harford Rd.

VS 151

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CERTIFICATE CORRECTED 6-28-49

G75477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75477

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Bertha E. Loomis

2. DATE OF DEATH June 18-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5335 Resterstown Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 71 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-1
D. STREET ADDRESS (If rural, give location) 5335 Resterstown Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married	Feb. 19-1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homes wife	ax Homes	Baltimore Md.	U.S.A.

13. FATHER'S NAME Frederick William Wieneke

14. MOTHER'S MAIDEN NAME Katherine Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	—	Charles L. Loomis	5335 Resterstown Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrage — Interval between onset and death: 6/12/49

DUE TO

(B) Ch. Myocarditis — 1947

DUE TO

(C) Ch. Pseudohypertrophic Nephritis — 1947

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Oct. 15 1948 to June 18, 1949, that I last saw the deceased alive on June 17, 1949, and that death occurred at 12:05 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul Brown M.D.	1633 W. North Ave.	6/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-21-49	David Ridge	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	Wm. J. Beckner & Sons	Balto., Md.

VS 150

131B

G75478

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

450.0 G75478

Registered No.

1. NAME OF DECEASED (Type or Print): LILLIE MAE FLAHARTY

2. DATE OF DEATH: June 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2911 W. North Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2911 W. North Ave. 15-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	widowed.	Mar. 11, 1868	81 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
unknown Schmidt	unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—		—	Mr. Arthur J. Hergenroeder	Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility & arteriosclerosis

DUE TO

(B) uremia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
—	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* July 1944 *to* June 17, 1949 *that I last saw the deceased alive on* June 17, 1949 *and that death occurred at* 10 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	3033 W North Ave	6/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/20/49	Lorraine Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

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G75479 ✓ X G75479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420 · Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET Bo[illegible] Quirk

2. DATE OF DEATH June 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Elkridge
D. STREET ADDRESS (If rural, give location) 1711 Levering ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	W.	widowed	3-19-1867	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Maryland	

13. FATHER'S NAME: Benjamin Stinefelt

14. MOTHER'S MAIDEN NAME: Mary Margaret Stricker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		no	Dr. H. Raymond Peters	501 Anneslie Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY OCCLUSION
DUE TO SMALL INFARCT TO RT. MIDDLE LOBE.
(B) HYPERTENSIVE ARTERIOSCLEROTIC
DUE TO CARDIO VASCULAR DISEASE & MITRAL STENOSIS AND
(C) BILATERAL PULMONARY EDEMA -
DIABETES MELLITUS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5/31, 1949 *to* 6/19, 1949 *that I last saw the deceased alive on* 6/19, 1949 *and that death occurred at* 4:45 *P.M., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John H. Adams M.D.	St. Agnes Hosp.	6/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/22/49	Cem. St. Augustine's Catholic	Elkridge, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

61

G75480

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 G75480 Registered No.

1. NAME OF DECEASED (Type or Print): HELEN M. MUNRO

2. DATE OF DEATH: 6-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital
C. Length of stay in Baltimore: 50 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore #12
D. STREET ADDRESS (If rural, give location): 404 E. Lake Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Fe	White	Single	April 2, 1888	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Music teacher		Belgium	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert E. Munro	Janet C. Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No	no	Mr. Wm. G. Munro, 6006 Pinehurst Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs

DUE TO

(B) Rt. internal Capsule
Hypertensive cardiovascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Generalized arteriosclerosis
Kyphoscoliosis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-17, 1949 *to* 6-18, 1949 *that I last saw the deceased alive on* 6-18, 1949 *and that death occurred at* 11:40 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lee Howard, M. D.	Church Home & Hosp.	6/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/21/49	Mt. Olivet Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

937

75481 ✓ X G75481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 17

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ~~TOWNSLEY~~ NELLIE JEREMIAS

2. DATE OF DEATH 6/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore — Yrs. — Mos. 10 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Queen Anne
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Stevensville
D. STREET ADDRESS (If rural, give location) —

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	W	1883	66	-	-	-	-

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housemaid	—	Md. (Delair)	U.S.A.

13. FATHER'S NAME George W. Townsley

14. MOTHER'S MAIDEN NAME Mary Dever

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	no	Mary Holbein	Stevensville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac & respiratory failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Carcinomatosis - generalized

DUE TO

(C) Ca of cervix - grade IV

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/8/ 1949 to 6/18/ 1949 *that I last saw the deceased alive on* 6/18 1949 *and that death occurred at* 6 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
F. J. Shenehan M.D.	University Hospital	6/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/21/49	Woodlawn Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

48a

Submission Approved

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 G75482 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DARRAH JOHN JEFFERSON POPE (POPS)

2. DATE OF DEATH 6/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2316 Sd. Ave. 16

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	single	Mar. 25, 1890	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
storekeeper	Bakers	Jackson, N.C.	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-		577-03-5316	Mr. J. Eugene Sours	5619 Ashbourne Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebro vascular Accident
DUE TO
(B) Hypertensive Arteriosclerotic cardiovascular disease (Fractured rt. hip, possible)
DUE TO
(C) Fracture

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION OF PHYSICIAN
Per: Ruth Ryan

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	White Coffee Pot Rest.	Sidewalk immediately in front of White Coffee Pot Restaurant

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY Ooccur?
June 17, 1949 5 P.M. abt	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Hip injury as result of fall on sidewalk in front of White Coffee Pot Restaurant when person ahead of deceased fell on deceased

22. *I hereby certify that I attended the deceased from* 5:10 P.m. 6/17, 19 49 *to* 8:20 6/17, 19 49 *that I last saw the deceased alive on* 6/17, 19 49, *and that death occurred at* 8:20 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Katharine V. Kemp M. D.	West Balto Gen Hosp	6/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/20/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Theodore Lee Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

937

G25483 B.C.H.-45776 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G25483

1. NAME OF DECEASED (Type or Print): Benjamin Warren Norton, Jr.

2. DATE OF DEATH: June 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3300 Forrest Park Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3300 Forrest Park Ave. 15-38

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	single	April 16, 1946	3 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Baltimore, Md.	

13. FATHER'S NAME: Benjamin Warren Norton, Sr.

14. MOTHER'S MAIDEN NAME: Dorothy E. Fleagle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		no

17. INFORMANT: Mr. Benjamin W. Norton, Sr. ADDRESS: 3300 Forest Park Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or compilation which caused death.)
(A) Pulmonary edema
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY. (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
Earl L. Royer M.D.		June 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/21/49	Moreland Mem. Pk.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 151

111 C

G75484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75484 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CAROLINE E. REED

2. DATE OF DEATH 6/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2710 Eylburn Ave.

C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2710 Eylburn Ave. 27-17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Jan 23 1863	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	—	Md.	

13. FATHER'S NAME David Flower.

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Denman M. Reed Sr.	2710 Eylburn Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic hypertension

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A), STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 1 '49 *to* June 1 '49 *that I last saw the deceased alive* June 16 '49, *and that death occurred at* 1:30 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bruce Stoudtmn M. D.	1434 Hunt Ave	June 20 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	6/20/49	Woodlawn	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	Paul Chalkley	3650 Chestnut Ave

VS 150

937

G75485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75485

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ida V. George

2. DATE OF DEATH 6-18-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 928 E. Eager St.

c. Length of stay in Baltimore 61 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City

D. STREET ADDRESS (If rural, give location) 928 E. Eager St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	May 10, 1888	61	1	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House work	at Home	Baltimore, Md.	U.S.A.

13. FATHER'S NAME Henery Simmons

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	Mr. James E. George	928 E. Eager St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Infarction

DUE TO

(B) Ch. Hypertension

DUE TO

(C) Ch. Myocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/2 *,* 1948 *, to* 6/12 *,* 1949 *that I last saw the deceased alive on* 6/12 1949 *and that death occurred at* 6 A.M. *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. L. Hornstein M. D.	204 E. Biddle St	6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-21-1949	Memorial Pk. Cemetery	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	Elmer W. Conklin	924 E. Eager St.

VS 150

935

G75486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75486

BIRTH NO. B.C. 49-12274

1. NAME OF DECEASED (Type or Print): Martin, Baby Boy

2. DATE OF DEATH: June 15, '49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore

c. Length of stay in Baltimore: 1 Day (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 2128 Eastern Ave. 1-2

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: June 17, 1949

9. AGE (In years last birthday) If under 1 year: Months / Days; If under 24 hours: Hours / Min.: 30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Ivy Martin

14. MOTHER'S MAIDEN NAME: Eleanor Mary Bogdan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Father ADDRESS: 2128 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Congestion (Atelectasis ?)

DUE TO

(B) Prematurity.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 17, 1949, to June 18, 1949, *that I last saw the deceased alive on* June 18, 1949, *and that death occurred at* 3:05 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Philip A. Pate M.D.

23B. ADDRESS: 1400 N. Carolina St

23C. DATE SIGNED: June 18, 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 6/20/49

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Fidelity Funeral Dir. ADDRESS: 1085 Wash St.

VS 150

159

G75487

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1 80

G75487

Registered No.

1. NAME OF DECEASED (Type or Print): Robert Harry McKalvey

2. DATE OF DEATH: June 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR [redacted] (If not in hospital or institution, give street address or location): St. Joseph's

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1919 W. Franklin St.

5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: JAN 7-1892
9. AGE (In years last birthday): 57
If Under 1 Year: Months: 5 Days: 13
If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hancock, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert E. McKalvey
14. MOTHER'S MAIDEN NAME: Fannie McKinley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized carcinomatosis

DUE TO

(B) Hypernephroma, Right kidney

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(INTERVAL BETWEEN ONSET AND DEATH)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* May 1, 1949 *to* June 20, 1949, *that I last saw the deceased alive on* June 20, 1949 *and that death occurred at* 4:45a m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. Andrew Aeuss, M. D.
23B. ADDRESS: St. Joseph's Hospital
23C. DATE SIGNED: 6-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 6/23/49
24C. NAME OF CEMETERY OR CREMATORY: PRESBERTIAN
24D. LOCATION (City, town, or county) (State): HANCOCK, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 20 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, MD
25. FUNERAL DIRECTOR: Chas R. Towell 2427 E. Monument
ADDRESS

VS 150

52a

G75488 ✓ X ✓ G75488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Hattie Abrams

2. DATE OF DEATH 6-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Prince Geo.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Upper Marlboro
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	B	Single		37		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife (?)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Dan Abrams

14. MOTHER'S MAIDEN NAME Hattie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Hypertensive cardio-vascular renal disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-8-49, *to* 6-19-49, *that I last saw the deceased alive on* 6-19-49, *and that death occurred at* 10 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE John H Rosser M. D.

23B. ADDRESS University Hosp. Balto Md

23C. DATE SIGNED 6-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE June 22/49

24C. NAME OF CEMETERY OR CREMATORY Union

24D. LOCATION (City, town, or county) (State) Upper Marlboro Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949

REGISTERED IN Baltimore, Md.

25. FUNERAL DIRECTOR J. B. Johnson ADDRESS Annapolis, Md.

131a

Please write the cause of death clearly and legibly. Use no abbreviations. Physician: please write in ink.

G75489

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75489

1. NAME OF DECEASED (Type or Print): Edward W. Rodey

2. DATE OF DEATH: June 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore Gen'l. Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: A.A.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brooklyn (25)
D. STREET ADDRESS (If rural, give location): 935 1st St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct. 5, 1920
9. AGE (In years last birthday): 28
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Galvanizer
10B. KIND OF BUSINESS OR INDUSTRY: Md. Bolt & Nut Co.
11. BIRTHPLACE (State or foreign country): Balto., Md.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edward C. Rodey
14. MOTHER'S MAIDEN NAME: Anna M. Keyes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-05-2744
17. INFORMANT: Mrs. Anna M. Rodey
ADDRESS (Wife): 4025 Belle Grove Rd., Brooklyn 25, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ACUTE PULMONARY EDEMA
DUE TO
(B) HYPERTENSIVE HEART DISEASE
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
DIABETES MELLITUS & NEPHROSCLEROSIS

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JUNE 18, 1949 *to* JUNE 18, 1949 *that I last saw the deceased alive on* JUNE 18, 1949 *and that death occurred at* 10:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Samuel P. Scalia M. D.
23B. ADDRESS: South Baltimore Gen. Hospital
23C. DATE SIGNED: June 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 22, 1949
24C. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
24D. LOCATION (City, town or county) (State): A.A. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: R. J. Howard Evans
ADDRESS: 1400 N. Charles St., Baltimore 30, Md.

VS 150

61

G75490

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75490

Registered No.

1. NAME OF DECEASED (Type or Print) Ernest Weiland

2. DATE OF DEATH Sat. June 18-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1432 Woodall Av.

C. Length of stay in Baltimore Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore — 24-07
D. STREET ADDRESS (If rural, give location) 1432 Woodall Av.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Sept. 2, 1872	(76)	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cabinet Maker Ret.	Ripley Centers	Baltimore, Md.	U.S.A.

13. FATHER'S NAME Rodolph Weiland

14. MOTHER'S MAIDEN NAME Ernestine Rolfe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		217-01-7239	Mrs. Johanna Weiland, Wife	(Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Chronic Myocardial Degeneration	1 yr.
DUE TO (B)	Arteriosclerosis	2 yr.
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore, City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1948 *to* June 18, 1949, *that I last saw the deceased alive on* 6-17, 1949, *and that death occurred at* 2 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Holland M. D.	707 Font Ave.	6-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 21, 1949	Cedar Hill Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	A. J. Howard Evans	1400 S. Charles St. Baltimo 39 Md 931

VS 150

Correct age is especially important. Physician please write the cause of death clearly and legibly.

G75491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

v.1

G75491 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BOWEN NORMA STRICKLER

2. DATE OF DEATH 6-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland University Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hosp.
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto. City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 1801 South Road 27-15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	WHITE	Married	Apr / 1884	65 63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Balto. Co., Md.	U.S.A.

13. FATHER'S NAME Dr. Josiah L. Bowen

14. MOTHER'S MAIDEN NAME Norma R. Mears

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
None	None	None

17. INFORMANT Mr. LeRoy Stiebler ADDRESS 1801 South Road

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Resp. failure	
DUE TO	(B) carcinoma of salivary gland	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	(C) & pulmonary metastasis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Intestinal obstruction	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-3-49, 19__, *to* 6-17-49, 19__, *that I last saw the deceased alive on* 6-17-49, 19__, *and that death occurred at* 10P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John White M. D.	University Hospital	6-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June-20-1949	Druid Ridge	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	Stewart & Mowen Co.	108 W. North Ave Balto. #1, Md.

VS 150

45c

Cover age is especially important. Physician: please write the cause of death clearly and legibly.

G75492 ~~443~~ G75492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Ida Henrietta EISENBRANDT. 2. DATE OF DEATH: June-17-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3502 Clifton Av

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Nursing Home.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22-14
D. STREET ADDRESS (If rural, give location) 110 Hawthorne Rd-Cty 10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If less than 1 day: Months, Days	If less than 24 hours: Hours, Min.
Female	White	Widow	Feb/2/1866	83-4-15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Baltimore, Md.	U.S.

13. FATHER'S NAME: Henry Fuchs

14. MOTHER'S MAIDEN NAME: Caroline Wild.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	none	Mrs Dorothy A. Eisenbrandt	Bel

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-Sclerosis

DUE TO Myocarditis

Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Gradual

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1944 *to* June 17, 1949, *that I last saw the deceased alive on* June 17, 1949, *and that death occurred at* 10:20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	1403 Park Ave	6-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 20/49	Lorraine	Bello Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Turington Williams, M.D.	Steward Moran Co.	Balto.

VS 150

931

G75493

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75493

Registered No.

1. NAME OF DECEASED (Type or Print) Catherine Ellen Lloyd-

2. DATE OF DEATH June 18 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland 302 Wyndhurst-
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at home
c. Length of stay in Baltimore 60 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland - B. COUNTY Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-12
D. STREET ADDRESS (If rural, give location) 302 Wyndhurst Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED OR DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Feb 22 1871	78 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	St Marys Co. Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William G. Floyd	Mary Mills

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	none	Mrs Mary E Lloyd-	302 Wyndhurst

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: Feb 1949
DUE TO
(B) Arterio-sclerosis — Gradual
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1948 *to* June 18, 1949, *that I last saw the deceased alive on* June 18, 1949, *and that death occurred at* 7 45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M.D.	1402 Park ave	6-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 21-	New Cathedral	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	(Mrs) Huntington Williams, M.D.	Stewart Morris Co.	Balto

VS 150

937

G75494

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Reg. 1 G75494 Registered No.

1. NAME OF DECEASED (Type or Print) Sister Elizabeth Driscoll

2. DATE OF DEATH June 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Seton Institute

c. Length of stay in Baltimore 50 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15 28 of
D. STREET ADDRESS (If rural, give location) 6420 Reisterstown Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	Single	1-19-1867	82				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sister of Charity		Pennsylvania, U.S.A	U.S.A

13. FATHER'S NAME Dennis Driscoll

14. MOTHER'S MAIDEN NAME Margaret Hennessy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO		

17. INFORMANT The Seton Institute - 6420 Reisterstown Rd. ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic myocarditis	20 yrs
	DUE TO Arterio-sclerosis	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Hypertension & Myocardial infarcts	
	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) Cardio-vascular collapse	1 day

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from April, 1928 to 6/19, 1949 that I last saw the deceased alive on 6/19, 1949 and that death occurred at 1:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Samuel P. Alagia M. D.	936 Fawn St	6/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	6/21/49	Seton Institute	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	Sherwood & Hoover	109 W. North

93D

To be O.K'd by Medical Examiners Office ✓

G75495 — BALTIMORE CITY HEALTH DEPARTMENT — E903,0 — G75495

BIRTH NO. — **CERTIFICATE OF DEATH** — Registered No.

1. NAME OF DECEASED (Type or Print): PHILIP W. FOWLER — 2. DATE OF DEATH: 6/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
c. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1907 McKEAN AVE 15-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	WIDOWED	7/28/70	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retail Salesman	Furniture Store	MARYLAND, Carroll Co.	U.S.A

13. FATHER'S NAME: WILLIAM FOWLER
14. MOTHER'S MAIDEN NAME: CATHERINE HUNTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		ETHEL FOWLER	SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DIABETES MELLITUS, ACIDOSIS
DUE TO
(B) HYPOSTATIC PNEUMONIA — 3 WKS.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO AND
(C) HYPERTENSIVE C.V.D — 20 YRS.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
FRACTURE OF LEFT HIP — 4 WKS

CERTIFICATION APPROVED BY
For Chief Medical Examiner
Per: G. G. Merrill M.D.
ASST. CHIEF MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	M. O.
ACCIDENT	HOME	1907 McKEAN	15/4

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5/21/49 10:00 A.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	FELL WALKING TO PHONE (Slipped + Fell TO Floor)

22. *I hereby certify that I attended the deceased from* 5/21, 1949 *to* 6/18, 1949, *that I last saw the deceased alive on* 6/17, 1949, *and that death occurred at* 2:45 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul G. Hersh M. D.	Maryland General Hospital	6/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/21/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

186a

Please write the cause of death clearly and legibly. Physician's please, write in especially important. Correct age is especially important.

G75496

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. G75496

1. NAME OF DECEASED (Type or Print) Catherine Cronin

2. DATE OF DEATH June 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Pine Crest Nursing Home

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
92 W. Mosher St. 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	10/25/1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Milliner		Baltimore Co., Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Philip Cronin	Catherine Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Milderd S. Cassidy	701 Cathedral St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — Interval between onset and death: June 15, 1949

DUE TO

(B) Arteriosclerosis — ?

DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bronchopneumonia — 3 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 11, 1949, *to* June 19, 1949, *that I last saw the deceased alive on* June 18, 1949, *and that death occurred at* 12.40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Melvin N. Borden M. D.	2030 E. Fayette St.	June 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 21, 49	Cathedral Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 20 1949

REGISTRAR'S SIGNATURE: Huntington Robinson, M.D.

25. FUNERAL DIRECTOR: Chas F. Evans & Son Inc. — ADDRESS: 830 118 W. Mt. Royal Ave.

VS 150

Please write the cause of death clearly and legibly. Get age if unknown. Physician: please write plainly.

G75497

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6/0

G75497

Registered No.

1. NAME OF DECEASED (Type or Print) **Joseph Chiariello**

2. DATE OF DEATH **June 18, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **2814 Boarman Ave.**

c. Length of stay in Baltimore **22** Yrs. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **2814 Boarman Ave.,** 15-13

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
male	white	married	Aug. 30, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ladies Clothing Designer.	Clothing	Italy	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Chiariello,	Maria Norchia,

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Mrs. Mary Chiariello,	2814 Boarman Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	few hrs
DUE TO (B)	Arterial Hypertension	2 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A), STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Chronic Prostatitis & Prostatectomy	08978
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-8-, 1948 *to* June 18, 1949, *that I last saw the deceased alive on* 6/18, 1949 *and that death occurred at* p. m., *from the causes and on the date stated above.*

23A. SIGNATURE, M. D.	23B. ADDRESS	23C. DATE SIGNED
Lee Nichols	1402 Reisterstown Rd.	6-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	6/22/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	L. Vernon Lemmon	4611 Park Heights Ave.

VS 150

83a

G75498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75498

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DAVID ROTHE

2. DATE OF DEATH 6/19/49

3. PLACE OF DEATH: Baltimore City, Maryland 3725 Leverton Ave

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Md
b. COUNTY
c. CITY OR TOWN Baltimore
D. STREET ADDRESS (If rural, give location) 3725 Leverton Ave

5a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. 5 Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	W.	5/13/1898	51				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maintenance man	Shipyard	Baltimore Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Rothe	Johanna Kleis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes W.W. I	212-10-2249	Claud J. Rothe	2901 Lee Ave Balto

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

Autopsy, Inspection or Inquiry

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
John R Davis, M.D.		6/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/22/49	Oak Lawn	Catonsville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	Ulman Funeral Home	709 E Fayette St

VS 151

937

G75499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75499

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sylvia Price

2. DATE OF DEATH June 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore 30 Yrs. (Yrs., Mos., Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 226 East St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
F	C	Widow	Jan. I. 1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Washington Dc	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Jones	Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Anna Mae Childs 226 East St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Degenerative Degeneration

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE: WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl Bryan M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED June 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 21 49	Mt Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Elroy O. Wilson 1000 Brantly Ave.

VS 151

93D

correct age is especially important. Physician: please write the cause of death clearly and legibly.

N M. 129724 BALTIMORE CITY HEALTH DEPARTMENT G75500
75500 BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Samuel , Carey. 2. DATE OF DEATH June 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore 45 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE ? B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ? 3-01
D. STREET ADDRESS (If rural, give location) 113 S. Caroline St. OR 116

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	Negro	Single	6/29/1888	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unkown ?
14. MOTHER'S MAIDEN NAME Unkown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT B.C.H. Records ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxia.
DUE TO
(B) Amerurysm of the Aorta and Innominate Artery.
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 17. , 1949 *to* June 18. , 1949 *that I last saw the deceased alive on* June 18, 1949 *and that death occurred at* 9.15A m., *from the causes and on the date stated above.*

23A. SIGNATURE C. S. Rogers M. D.
23B. ADDRESS B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED June 19, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/21/1949	Mt Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 20 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Elroy O. Wilson 1000 Brantly Ave.

VS 150

301

G75501

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H 5.0.0 G75501

Registered No.

1. NAME OF DECEASED (Type or Print) ELLA COOPER

2. DATE OF DEATH June 17th, 194[illegible]

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ardleigh Nursing Home

c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 327 East 21st Street 12-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	1861	88				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
---	At Home	Baltimore Co.	

13. FATHER'S NAME (?)

14. MOTHER'S MAIDEN NAME Winfred Finn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
--	--	--

17. INFORMANT GREGORIUS ADDRESS
Miss. Eleanor [redacted] 327 E. 21st St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs

DUE TO —

(B) —

DUE TO —

(C) —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 1, 1942 *to* June 12, 1949 *that I last saw the deceased alive on* June 12, 1949 *and that death occurred at* 3:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. A. Flynn M.D. M. D.	11 E. Chase St	6/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/20/49	St. Mary's Govans	City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 20 1949	Huntington Williams, M.D.	WIEDEFELD AND SON GREENMOUNT AVE. & 22nd ST.

97

Correct age in especially important. Always use words; please write distinctly.

G75502

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75502

1. NAME OF DECEASED (Type or Print): John Daniel Hemacost.

2. DATE OF DEATH: 6-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: 6 ~~Years~~ ~~Months~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Carroll
C. CITY OR TOWN: Finksburg (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	15 April 1869	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Retired

10B. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George W Armacost

14. MOTHER'S MAIDEN NAME: Virginia E. Herring

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Records ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be completed. Please write the cause of death clearly and legibly. Correct age is especially important. Physician please write

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Trans Urethral Prostatectomy (Prostatectomy)

DUE TO

(B) Chronic Glomerular Nephritis

DUE TO

(C) Arteriosclerotic C. V. D.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 6-20-49.

19B. MAJOR FINDINGS OF OPERATION: Benign Prostatic Hypertrophy

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-14, 1949 *to* 6-23, 1949 *that I last saw the deceased alive on* 6-20, 1949 *and that death occurred at* 9:20 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: W. K. Bender M. D.

23B. ADDRESS: Md. Gen. Hosp.

23C. DATE SIGNED: 6-6-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 6-23-1949

24C. NAME OF CEMETERY or CREMATORY: Finksburg

24D. LOCATION (City, town, or county) (State): Finksburg Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: J. E. Myers Sr. ADDRESS: Westminster Md.

VS 150

137a

G75503

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

16 G75503
Registered No.

BIRTH NO. B.C.49-1295

1. NAME OF DECEASED (Type or Print) Baby Mary Stebley

2. DATE OF DEATH 6/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28-01
D. STREET ADDRESS (If rural, give location) 3614 Woodbine Ave

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 6/19/49
9. AGE (In years last birthday) — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min. 3 45
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Benjamen
14. MOTHER'S MAIDEN NAME: Doris Kohl
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity — Non-Usable
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/19, 1949 *to* 6/19, 1949, *that I last saw the deceased alive on* 6/19, 1949, *and that death occurred at* 1:25 P m. *from the causes and on the date stated above.*

23A. SIGNATURE — M. D.
23B. ADDRESS St. Agnes Hosp
23C. DATE SIGNED 6/20

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 21/1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town or county) (State): Baltimore
25. FUNERAL DIRECTOR — ADDRESS: Harry M. Thomas 4204 Gridywood Ave

DATE RECEIVED BY LOCAL REGISTRAR: JUN 20 1949
REGISTRAR'S SIGNATURE: Thurlington Williams

VS/150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. If none, write none. If unknown, write unknown. Physician please write the cause of death clearly and legibly. Correct age is especially important.

G75504

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75504

Registered No.

1. NAME OF DECEASED (Type or Print) FANNIE COPPAGE

2. DATE OF DEATH 6/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.

c. Length of stay in Baltimore 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
A. STATE Md. B. COUNTY Queen Annes
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Church Hill
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
F	W		4-1-1867	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper		Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm. E. Smith	Fannie Wallace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Brother	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Uterus — DUE TO

ANTECEDENT CAUSES

(B) Embolism — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) — DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 4/27 1949, to 6/22, 1949, that I last saw the deceased alive on 6/20, 1949 and that death occurred at 11 30 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dulaney Mallis M. D.	University Hosp	6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/23/49	Church Hill	Church Hill Q.A. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	Edgar L. Lane	Church Hill, Md.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Write the cause of death clearly and correct age is especially important. Physician: please write the

48a

G75505

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

154 Registered No. G75505

1. NAME OF DECEASED (Type or Print): JOEN JOSEPH BURKE

2. DATE OF DEATH: June 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Mass.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Somerville
D. STREET ADDRESS (If rural, give location): 5 Bank St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 9/19/96
9. AGE (In years last birthday): 52
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10B. KIND OF BUSINESS OR INDUSTRY: Seafarer

11. BIRTHPLACE (State or foreign country): Milford, Mass.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin J. Burke

14. MOTHER'S MAIDEN NAME: Ellen ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 033-03-6405

17. INFORMANT: Records-US Marine Hospital, Balto, Md.
ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given and every question answered. Write the cause of death clearly and legibly. Correct age in especially important. Physician: please write this certificate completely.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma of rectum with generalized metastases — Interval between onset and death: 1 yr.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 16, 1949, *to* June 20, 1949, *that I last saw the deceased alive on* June 20, 1949, *and that death occurred at* 1:20A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson M. D.

23B. ADDRESS: US Marine Hospital, Balto, Md.

23C. DATE SIGNED: 6/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 6-20-49

24C. NAME OF CEMETERY OR CREMATORY: Somerville Mass

24D. LOCATION (City, town, or county) (State): Somerville Mass

DATE RECEIVED BY LOCAL REGISTRAR: JUN 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Earl B. Shorten

ADDRESS: 403-E 25th St

VS 150

461

G75506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450.0 G75506

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Adolph J. Schimanski

2. DATE OF DEATH 6/18/49 7:55 P.M.

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pine Crest Nursing Home 600 S. Chapel Gate Lane

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. R.F.-31
D. STREET ADDRESS (If rural, give location) 600 S. Chapel Gate Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Widowed	10/31/1864	84	7 / 17	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Reading R. R.	Poland	

13. FATHER'S NAME: John Schimanski

14. MOTHER'S MAIDEN NAME: Bertha (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		None

17. INFORMANT: Emil A. Schimanski, 230 W. Eldorado Rd, Brooklyn Park

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility cathremia — INTERVAL BETWEEN ONSET AND DEATH: 1-2 yrs
DUE TO dementia
(B) Generalized arteriosclerosis ?
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic myocarditis with degeneration ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
/ / m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* December 21, 1948, *to* June 18, 1949, *that I last saw the deceased alive on* June 18, 1949, *and that death occurred at* 7:55 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Melvin H. Borden M. D.	2030 W. Fayette St	6/20/49

24A. ~~BURIAL, CREMATION~~, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Removal	6/23/49	Evergreen	Camden N.J.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 20 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Prepare the certificate of death clearly and legibly. Correct age is especially important. Physician please write the cause

937

G75507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 31

Registered No. G75507

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY BAYER

2. DATE OF DEATH 6-19-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 833 W. Lombard St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Md. b. COUNTY

c. CITY OR TOWN Balto (If outside corporate limits, write RURAL and give township) 18 + 3

d. STREET ADDRESS (If rural, give location) 833 W. Lombard St

c. Length of stay in Baltimore 67 Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
F	W		May 17, 1882	67	1	2	-	-

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (State or foreign country) Balto Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT John F. Bayer ADDRESS 833 W. Lombard St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Hemorrhage	5 hrs
DUE TO	(B) Generalized Arteriosclerosis	3 yrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1946 *to* June 19, 1949 *that I last saw the deceased alive on* June 19, 1949 *and that death occurred at* 9:55 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE Earl Pass M. D.

23B. ADDRESS 4001 W Ilchester Ave

23C. DATE SIGNED 6-19-49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify) Burial

24B. DATE 6/22/49

24C. NAME OF CEMETERY OR CREMATORY London Park

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 21 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm. Gok Inc. ADDRESS 1217 St. Paul St.

VS 150

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physician please write the cause of death clearly and legibly. Correct age is especially important.

75508

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75508
Registered No.

1. NAME OF DECEASED (Type or Print) Henry WeKenMun

2. DATE OF DEATH 6/20/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 704 Cathedral St. 11-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	6/10/1884	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Wholesale Drug Clerk	Maryland	

13. FATHER'S NAME John WeKenman

14. MOTHER'S MAIDEN NAME Josephine Denges

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Leonard Sims	Roland Pk. Apts

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Erase, write over or use abbreviations. Correct age is especially important. Physician: please write the cause of death clearly and fully.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach

DUE TO

(B) Subdiaphragmatic Abscess

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/20/49 19__, *to* 6/20/49, 19__, *that I last saw the deceased alive on* 6/20/49 19__ *and that death occurred at* 12:05 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	SBGH	20 June 49

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/23/49	Holy Redeemer	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 150

46B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 G75509 Registered No.

5509 BIRTH NO.

1. NAME OF DECEASED (Type or Print) James A. Watson

2. DATE OF DEATH June 19/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

C. Length of stay in Baltimore 30 yrs. (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 1918 Madison St 16-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M.	Col.	Married	June 27, 1905	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker

10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country) Prince Edward County Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Watson

14. MOTHER'S MAIDEN NAME Johanna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Mallie Watson ADDRESS 2023 Harlem Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension Cardiovascular Disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-16- 1949 *to* 6-19 1949 *that I last saw the deceased alive on* 6-19 1949 *and that death occurred at* 7:20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.

23B. ADDRESS

23C. DATE SIGNED 6-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE June 24 1949

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.

24D. LOCATION (City, town, or county) (State) A.A. County Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 21 1949

REGISTRAR'S SIGNATURE Williams, M.D.

25. FUNERAL DIRECTOR Mrs. Dott A. Ellis & Daughter ADDRESS 1124 N. Carrollton St. 93

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Write the cause of death clearly and legibly. Correct age is especially important. Physician please write

G75510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75510

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CORA VIRGINIA MAGOWAN

2. DATE OF DEATH 6-18-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore 83 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE. 13-07
D. STREET ADDRESS (If rural, give location) 2135 BOLTON ST. BALTIMORE Md

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	W	OCT 1, 1865	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME HENRY KUHL

14. MOTHER'S MAIDEN NAME ALVERDA VIRGINIA RICKTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT SISTER (MISS KUHL) ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) APOPLEXY. CEREBRAL HEMORRHAGE.	2 hrs.
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-18 *1949 to* 6-18 *, 1949 that I last saw the deceased alive on* 6-16 *, 1949, and that death occurred at* 9:25 A *m., from the causes and on the date stated above.*

23A. SIGNATURE W. P. Benson, Jr. M. D. | 23B. ADDRESS Union Memorial Hosp | 23C. DATE SIGNED 6-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/21/49	Woodlawn	Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 21 1949 | REGISTRAR'S SIGNATURE [illegible] Washington Williams, M.D. | 25. FUNERAL DIRECTOR. ADDRESS John O Mitchell & Sons, 1400 Eutaw St.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given if possible. Physician: please write the cause of death clearly and correct age is especially important.

830

75511
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75511
Registered No.

1. NAME OF DECEASED (Type or Print): Cleo Johnson

2. DATE OF DEATH: 6-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 640 Jasper St. 17-01

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: 33 yrs. (Yrs. Mos. Days)

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 5-1-1898
9. AGE (In years last birthday): 51 (If Under 1 Year: Months 1, Days 18; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC
10B. KIND OF BUSINESS OR INDUSTRY: PRIVATE
11. BIRTHPLACE (State or foreign country): Greensboro N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ALICE JOHNSON. ADDRESS: 640 JASPER ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Diabetic Acidosis
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-12-1949, to 6-18-1949, that I last saw the deceased alive on 6-18-1949, and that death occurred at 1:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: Provident Hosp
23C. DATE SIGNED: 6-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 6-22-49
24C. NAME OF CEMETERY OR CREMATORY: MT. AUBURN
24D. LOCATION (City, town, or county) (State): BALTIMORE

DATE RECEIVED BY LOCAL REGISTRAR: JUN 27 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Wm. A. JACKSON
ADDRESS: 916 PENNA. AVE.

VS 150

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

G75512

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75512
Registered No.

1. NAME OF DECEASED (Type or Print): MEYER SHER

2. DATE OF DEATH: 6-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2659 Oswego Ave

c. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-13
D. STREET ADDRESS (If rural, give location): 2659 Oswego Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last Birthday): 60 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Tailor

11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Cecelia Sher ADDRESS: 2659 Oswego

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Please write the cause of death clearly and correct age is especially important. Physician: please write t

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO
(B) Acute Pulmonary Edema. Hypertensive Cardiac Hypertrophy — 3-4 years
DUE TO
(C) Post Cerebral Accident — 8 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1948 to June 20, 1949 that I last saw the deceased alive on 6-20, 1949 and that death occurred at 4:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE: Theodore Cooper, M.D. M. D.
23B. ADDRESS: 9201 Eutaw Place
23C. DATE SIGNED: 6/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-21-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

95B

CERTIFICATE CORRECTED 7-11-49

G75513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

G75513 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) YETTA SILVERMAN

2. DATE OF DEATH 6-20-49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 15-10

c. Length of stay in Baltimore 57 Yrs. Mos. Days

d. STREET ADDRESS (If rural, give location) 3818 Barrington Rd

6. SEX	7. COLOR OR RACE	8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	9. DATE OF BIRTH	AGE (In years if over 1 day)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	WIDOW	July 15, 1876	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work	Home	Russia	U.S.A.

13. FATHER'S NAME Alexander M.

14. MOTHER'S MAIDEN NAME Juliz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Moses Silverman	3772 Clarks Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lt. C-VA

DUE TO

(B) Hypertension.

DUE TO

(C) (Left cerebral vascular accident

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-20, 1949, *to* 6-20, 1949, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin K Silverman M. D.	Sinai Hosp.	6-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/21/49	Herring Run	Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 21 1949

REGISTRAR'S SIGNATURE: Livingston Williams, M.D.

25. FUNERAL DIRECTOR: Jack Levin Inc. ADDRESS: 2105 Eutaw Pl

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physician: please write the cause of death clearly and correct age is especially important.

VS 150

83a

G75514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-46

Registered No. G75514

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RICHARD WILLIAMS

2. DATE OF DEATH 6/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1354 Cleveland St

c. Length of stay in Baltimore 50yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1354 Cleveland 21-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	Widowed	1/17/1882	67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) A.A.County, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Richard Williams

14. MOTHER'S MAIDEN NAME Maria Suval

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mary Mason ADDRESS 577 Lafayette Av. N.Y.C.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician please write in ink. Please answer all questions. Items 19 to 21 are especially important.

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 24 hrs

DUE TO

(B) Hypertension, Neglected

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/3 *to* 6/16, 1949 *that I last saw the deceased alive on* 6/16, 1949 *and that death occurred at* 12 m., *from the causes and on the date stated above.*

23A. SIGNATURE David Swanker M. D.

23B. ADDRESS 1711 Lee St

23C. DATE SIGNED 6/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6/21/49

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn

24D. LOCATION (City, town, or county) (State) Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 21 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR Charles Harper ADDRESS 512 Carrollton Av.

VS 150

1310

G75515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 Registered No. G75515

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ERNEST A. OXLEY

2. DATE OF DEATH 6/15/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland (1505 Madison Ave. Baltimore, Md.)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City, Md.
D. STREET ADDRESS (If rural, give location) 1506 Madison Av 14-D

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If over 1 year last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
M	C	Married	6/7/1895	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cook		Jamaca, B.W.I.	U.S.A.

13. FATHER'S NAME: Ernest A. OXLEY

14. MOTHER'S MAIDEN NAME: Catherine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	086-16-0586	Estella Oxley (W)	1505 Madison Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular-Renal — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from June 9 1949 to June 16 1949, that I last saw the deceased alive June 16, 1949, and that death occurred at 11 40 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ben Shein M.D.	12 E. Centre St.	6/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/21/49	Mt. Auburn Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	Kenneth Williams, M.D.	Charles H. Corfe	512 Appleton

VS 150

131a

75516
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 675516
Registered No.

1. NAME OF DECEASED (Type or Print): WILTON S. CHALK.

2. DATE OF DEATH: June 19, 1949

3. PLACE OF DEATH: Baltimore City, Maryland / 1302 W. Lexington St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3736 Falls Road. 13-07

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home Of Our Lady.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	April 22/886	63 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Gardner	Roland Park Co	Maryland.	U. S.

13. FATHER'S NAME: George R. Chalk.

14. MOTHER'S MAIDEN NAME: Sarah E. Crosby.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Bertha I. Parker	1635 Union Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute Cardiac Dilitation	2 days
	DUE TO (B) Hypertension Cardio Vascular Renal	?
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Parkinson disease	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 1st, 1949 *to* June 18, 1949 *that I last saw the deceased alive on* June 18, 1949 *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Sherman M. D.	753 W. Fayette St	June 21. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	June 22/49	London Park	Frederick Rd - Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	[redacted]	Euston E. Donovan	3638 Roland Ave

VS 150

937

PLEASE WRITE LEGIBLY. Physician: please write the cause of death clearly and correct age is especially important.

GM. 129383

G75517

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 G75517
Registered No.

1. NAME OF DECEASED (Type or Print) Theresa Woodfolk

2. DATE OF DEATH 6- 20-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 24 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1211 N. Spring ST. Z 13

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	Negro	Married	Feb. 15-1902	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		VA.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ashley Bagley	Annie Folks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Records B. C.H.	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asphenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Failure
DUE TO Hypertensive Cardiovascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral Vascular Accident

INTERVAL BETWEEN ONSET AND DEATH: 3 Months

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 6- 3- 1949 *to* 6- 20 - 1949 *that I last saw the deceased alive on* 6- 20- 1949 *and that death occurred at* 10.45Am *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
P. S. Bozan M. D.	B.C.H. 4940 Eastern Ave.	6-20-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/23/49	Int. Calvary	A. A. County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	Huntington Williams, M.D.	Joseph B. Lord, Jr.	1304 N. Central

VS 150

937

Please write the cause of death clearly and correct age is especially important. Physician: please write

G75518

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

VS 40193 G75518

Registered No.

1. NAME OF DECEASED (Type or Print): ANTHONY G. BEIL

2. DATE OF DEATH: JUNE 20, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 933 S. BOULDIN ST.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 26-11
D. STREET ADDRESS (If rural, give location): 933 S. BOULDIN ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	1 Year: Days	If Under 24 Hours: Hours	Min.
MALE	WHITE	WIDOWED	MAY 5, 1885	64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		BALTIMORE, MD.	U.S.A.

13. FATHER'S NAME: ANTHONY BEIL

14. MOTHER'S MAIDEN NAME: CATHERINE STUMPF.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	

17. INFORMANT: CATHERINE DORN ADDRESS: 933 S. BOULDIN ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonic Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 6-10-46

DUE TO

(B) Myocardial Failure — 3-2-49

DUE TO

(C) Acute Coronary Occlusion — 6-20-49

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
None, m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 6-10 1946, *to* 6-20 1949 *that I last saw the deceased alive on* 6-19 1949, *and that death occurred at* 6:45 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ed Schimunk M. D.	842 E. 33rd St.	6-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
BURIAL	6-23-49	SACRED HEART	GERMAN HILL RD. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	Washington Williams M.D.	Charles S. Zeiler	901 S. Conkling St.

VS 150

95B

Please write plainly with pen and ink. Be sure to state the cause of death clearly and to correct age is especially important. Physician: please write the

G75519

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75519

1. NAME OF DECEASED (Type or Print) CARL GUYTON

2. DATE OF DEATH 6-18-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital

c. Length of stay in Baltimore 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Joppa
d. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	June 22, 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter		Maryland	USA

13. FATHER'S NAME Josiah Guyton

14. MOTHER'S MAIDEN NAME Louisa Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			M. A. Miller	C H H

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Lymphatic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-13, 1949 *to* 6-18, 1949, *that I last saw the deceased alive on* 6-18, 1949, *and that death occurred at* 11 25 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Carl Moore M. D.	Church Home & Hospital	6-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 22-49	Fork M. E. Cem.	Fork Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	Thurlington Williams, M.D.	Clarence E. Cutting	Fork Md

VS 150

74a

PLEASE WRITE CLEARLY — Fill in all blanks by typewriter or print. Be sure to state the cause of death clearly and correct age is especially important. Physician: please write the

G75520

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331 G75520

Registered No.

1. NAME OF DECEASED (Type or Print) Isabell Baxter

2. DATE OF DEATH June 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1408 Whitelock St.

c. Length of stay in Baltimore 3 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1408 Whitelock St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md.
D. STREET ADDRESS (If rural, give location) 1408 Whitelock St. 13-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Femal	Col.	Widow	12/25/92	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Georgetown nc	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Austin	Sylvia Pontsett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Evelyn Brown	1814 N. Caroline St.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY with pencil or pen and ink. Physician: please write the cause of death clearly and correct age is especially important.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Apoplexy — Interval between onset and death: 6-1-49

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B) 6-18-49
DUE TO
(C) arterio-sclerosis — 6 mos.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-1-49 *to* 6-18-49, *that I last saw the deceased alive on* 6-18-49 *and that death occurred at* 12 m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
Fr Landry	1524 Druid Hill Ave	6-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/23/1949	Georgetown Cem.	Georgetown Sc.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	[illegible] Wellington, Md.	Elroy O. Wilson	1000 Brantly Ave.

VS 150

830

KRAUSCH

G75521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75521

BIRTH NO. G75521

1. NAME OF DECEASED (Type or Print) Ruth M. Krausch

2. DATE OF DEATH June 19-1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hosp

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1523 Cole St

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Write)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Fem	White	Married	12/11/1909	39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	Self	Baltimore Md	

13. FATHER'S NAME Albert Krausch

14. MOTHER'S MAIDEN NAME Anna Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Florence A. Krausch	1523 Cole St

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Alcoholism — DUE TO

ANTECEDENT CAUSES

(B) — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
[signature]			19 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/22/49	Loudon Park	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	Huntington Williams, M.D.	Robt. C. & B. M. Watson	777 Cathedral St

V5151

If Physician, please write the cause of death clearly and legibly. Physician please write the correct age is especially important.

G75522
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

49°

G75522
Registered No.

1. NAME OF DECEASED (Type or Print) JAMES EDWARD DISTANCE

2. DATE OF DEATH June 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 738 West Mulberry Street 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
male	colored	married	Feb. 8, 1908	41				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) veteran
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Hezikiah Distance
14. MOTHER'S MAIDEN NAME Henrietta Tyson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Evelyn Distance — ADDRESS 2112 Pennsylvania Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Earl L. Penger M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED June 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	6-24-49	Baltimore National	Maryland

DATE RECEIVED BY LOCAL REGISTRAR JUN 21 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR — ADDRESS Geo. G. Kelson — 1303 Presstman Street

VS 151

108

G75524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

G75524 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Henry G. Weber

2. DATE OF DEATH June 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Bea[illegible] Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 150 N. Bureley St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6028 Old Harford Road

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore Life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 150 N. Bureley St. 6-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widow	Sept 5 1861	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Baltimore	U.S.A.

13. FATHER'S NAME Philip C. Weber

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—		Edna H. Weber	411 N. Bonsdin St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: One week

DUE TO

(B) Vascular Disease — Unknown

DUE TO

(C) Arteriosclerosis — Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 27, 1949, *to* June 19, 1949, *that I last saw the deceased alive on* June 19, 1949, *and that death occurred at* 6:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip Artigiani M. D.	2942 E. Fayette Street	6/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 23 1949	Mt. Carmel Cem.	O'Donnell St

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	Huntington Williams, M.D.	John C. Moran	3000 Wallace St

VS 150

83a

Please write the cause of death clearly and legibly. Physician's please write important, especially if age is especially important.

420.0 ✓

G75523 Jl - 129646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75523

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Benjamin Wilson

2. DATE OF DEATH June 19, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1709 Brentwood Ave. - 2 12-05 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Negro	Wid.	Feb. 2. 92	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ga.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Wilson (D)

14. MOTHER'S MAIDEN NAME Pettie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS 4940 Eastern Ave
Baltimore City Hospital Records

MEDICAL CERTIFICATION

PLEASE WRITE LEGIBLY. In items 18 and 21 please write the cause of death clearly and legibly. Omit terms such as "Chronic" or "Old age" as the cause of death. Please give exact cause of death, not symptoms or modes of dying. In item 18 please write the cause of death in the correct age is especially important. Physicians: please write in ink.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Generalized and Cerebral Arteriosclerosis ~~XXXX~~ Arteriosclerotic Heart Disease.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Fusiform Aneurysm of Aorta Syphilis

INTERVAL BETWEEN ONSET AND DEATH: 2 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES Yes NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) ... m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 4, 1949 *to* June 19, 1949 *that I last saw the deceased alive on* June 19, 1949 *and that death occurred at* 10.50 pm *from the causes and on the date stated above.*

23A. SIGNATURE J. S. Chozen M. D.

23B. ADDRESS B. C. H. 4940 Eastern Ave.

23C. DATE SIGNED 6-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE June 22-49

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.

24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 21 1949

REGISTRAR'S SIGNATURE Huntington Williams MD

25. FUNERAL DIRECTOR Elroy O. Wilson

ADDRESS 1000 Brantley Rd

VS 150

301

G75525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 19.4 G75525 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lorraine A. Matthews N-864-0

2. DATE OF DEATH June 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 108 W. Biddle St 11-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Single	Dec 1, 1930	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student Nurse
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Harmon, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Russell Matthews
14. MOTHER'S MAIDEN NAME Agnes Hawkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Madeline Matthews ADDRESS 108 W Biddle St

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY with unfading ink. Fill all blanks. Be sure the cause of death clearly and legibly. Physician: please write the cause correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Ruptured Spleen
DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Dorsey near Harmans a.a. Co.
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY June 18, 1949 2:05 A.M.
21E. INJURY OCCURRED WHILE AT [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? (Passenger in car) Auto into telephone pole

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X] suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED June 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 21, 1949
24C. NAME OF CEMETERY OR CREMATORY St. Rest
24D. LOCATION (City, town, or county) (State) Harmon Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 21 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mrs Kate R. Williams ADDRESS 322 N Schroeder St

VS 151

170c

G75526
BIRTH NO.

MARY

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75526
Registered No.

1. NAME OF DECEASED (Type or Print) — Mary Smith
2. DATE OF DEATH — June 17 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — 506 Pleasant St
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Baltimore
D. STREET ADDRESS (If rural, give location) — 506 Pleasant St 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col'd	Widowed	June 5 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	none	Virginia	U.S.A.

13. FATHER'S NAME — John Washington
14. MOTHER'S MAIDEN NAME — Louise Gaten

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Geo Washington - Walpline St	731

MEDICAL CERTIFICATION

Note the cause of death clearly and legibly. Physician please write the correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Myocardial Insufficiency	5 days
DUE TO (B)	Hypertensive C-V Renal	?
DUE TO (C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐, NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12/29 1948 *to* 6/17 1949, *that I last saw the deceased alive on* 6/15 1949 *and that death occurred at* 5 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Purton Grant M. D.	601 N. Carrollton	6/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 21, 1949	Mt. Zion	Langdowne, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	Washington Williams, M.D.	Mrs Katie R Williams	Edmondale

VS 150

1312

G75527

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75527

Registered No.

1. NAME OF DECEASED (Type or Print) Laurence Carter

2. DATE OF DEATH June 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 754 Vine St
C. Length of stay in Baltimore Lifetime Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 754 Vine St 4-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	Col	Married	Nov 2 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	none	Balto Md	U.S.A.

13. FATHER'S NAME John Carter

14. MOTHER'S MAIDEN NAME Ella

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT Elizabeth Williams ADDRESS 1000 Shillman Rd Cherry Hill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH 1 Yr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-2, 1949 *to* 6-18, 1949 *that I last saw the deceased alive on* 6-12, 1949 *and that death occurred at* m *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Atwell Jones M.D.	5-5-4 Dolfield Av	6-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 21, 1949	Mt. Auburn	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 21 1949 VS 150

REGISTRAR'S SIGNATURE: Curtis Williams, M.D.

25. FUNERAL DIRECTOR: Mrs. Katie R. Williams ADDRESS 2221 Schroeder St

131a

PLEASE WRITE the cause of death clearly and fully. Physician please write correct age is especially important.

Dr. Hood
2200 Garrison Blvd.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75528

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Howard F. Brehm

2. DATE OF DEATH: June 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2102 Elsinore Avenue
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2102 Elsinore Avenue 15-48

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept. 19, 1874
9. AGE (In years last birthday): 74
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob Brehm
14. MOTHER'S MAIDEN NAME: Catherine Lafferty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Virginia M. Brehm, 2102 Elsinore ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Pulmonary Edema & Uremia	9 days
DUE TO (B)	Cardio Vascular, Hypertension disease.	3 yrs
DUE TO (C)	—	
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 11, 1949 *to* June 20, 1949 *that I last saw the deceased alive on* June 19, 1949, *and that death occurred at* 9:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: M Bowman Hood M. D.
23B. ADDRESS: 2200 Garrison Blvd
23C. DATE SIGNED: June 20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-23-49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 21 1949
REGISTRAR'S SIGNATURE: Limestone for Williams M.D.
25. FUNERAL DIRECTOR: Leonard J. Ruck, 5305 Harford Rd. ADDRESS

VS 150

131a

Please write the cause of death clearly and legibly. Physician's signature is especially important. Be correct age is essential.

G75529

BIRTH NO. G75529

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 600

1. NAME OF DECEASED (Type or Print): John E. Burns

2. DATE OF DEATH: June 21 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sparrows Point
D. STREET ADDRESS (If rural, give location): 1322 Beechwood Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	W.	Apr. 16 1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Phila Pa.	U. S.

13. FATHER'S NAME: John J Burns

14. MOTHER'S MAIDEN NAME: Katherine McCarthy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Katherine Rathleb.	Phila Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

DUE TO

(B) Uremia — 3 months

DUE TO

(C) Chronic pyelonephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 16, 1949 *to* June 21, 1949, *that I last saw the deceased alive on* June 21, 1949, *and that death occurred at* 6:55 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. C. Hunter, M.D. M. D.	University Hospital	June 21 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	6/25/49	Holy Sepulchre Cem	Phila Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St Paul St Balto.

VS 150

133a

G75530

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75530

1. NAME OF DECEASED (Type or Print) JAMES CHITTUM (OR M.P.)

2. DATE OF DEATH JUNE 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Montgomery
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bethesda
D. STREET ADDRESS (If rural, give location) Read Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	SINGLE	1899	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNKNOWN		VIRGINIA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HENRY CHITTUM	CLARA BURNETT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		W.H. CHITTUM	GOODVIEW VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location.)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
M.D.		June 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
REMOVAL	6/21/49	BARNHART	BEDFORD VA.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	Huntington Williams, M.D.	Wm Cook Inc	1217 St Paul St.

VS 151

94a

Please write the cause of death clearly and legibly. Physician: please write the correct age in especially important.

G75631

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

185 X G75531 Registered No.

1. NAME OF DECEASED (Type or Print) CECEILO, SANDS

2. DATE OF DEATH 6/20/49

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp. Balto.

c. Length of stay in Baltimore 21 Yrs. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE 1221 Forest Park Rd B. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sparrows Point
D. STREET ADDRESS (If rural, give location) 1221 Forest Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W	Married	July 2, 1907	41 40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Millwright	Steel	Tom's Creek, Va.	USA

13. FATHER'S NAME: Martin Luther Sands

14. MOTHER'S MAIDEN NAME: Nannie Midkiff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	213-07-0151	Mrs. Elsie Sands	1221 Forest Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lower nephron nephrosis

DUE TO

(B) Acute necrotizing pancreatitis

DUE TO

(C) Acute cholecystitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/15/49 (?)		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/15/49, 19__, *to* 6/20/49, 19__, *that I last saw the deceased alive on* 6/20/49 19__, *and that death occurred at* 9:30P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lee N. Kastros, M. D.	3006 N. Milton St	6/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Burial	23 June, 49	Temple Hill Cem.	Coeburn, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	Huntington Williams, M.D.	Walter Brooke Bradley	700 Willow Spring Rd. Dundalk

VS 150 N.B. All the typed info. on this form supplied by Fun. Dir.

128

IRELAND ✓ X

G75532

BALTIMORE CITY HEALTH DEPARTMENT 776

CERTIFICATE OF DEATH

Registered No. G75532

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jeanie LaRue Ireland

2. DATE OF DEATH 6-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

c. Length of stay in Baltimore 4 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. COUNTY Calvert
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Plum Point
D. STREET ADDRESS (If rural, give location) —

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Fe	White	Single	6-16-49	0	4	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Md.	U.S.A.

13. FATHER'S NAME Joseph Wilson Ireland

14. MOTHER'S MAIDEN NAME Mary Elizabeth Laing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	—	

17. INFORMANT Joseph W. Ireland ADDRESS Plum Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity (Weight 1 lb 1 oz 3)
DUE TO —

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from 6-16- 1949 to 6-20 1949, that I last saw the deceased alive on 6-20 1949 and that death occurred at 10:59 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter C. Friday M.D.	Maryland Gen'l Hosp.	6-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 22, 1949	Christ Church	Port Republic Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 21 1949	Huntington Williams, M.D.	A. A. Harkins & Son	Mutual, Md.

VS 150

159

Please write the cause of death clearly and legibly. Physician's please write the exact age is especially important.

G75533 CERTIFICATE CORRECTED 7-14-49 ✓ 4 20 1 G75533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jeremiah E. Becker

2. DATE OF DEATH 6-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West. Baltimore General Hospital

C. Length of stay in Baltimore 20 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 724 E. 20th St #18 9-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed Divorced	7-2-'80	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY Penna R.R.

11. BIRTHPLACE (State or foreign country) Pa.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME David Beckmer

14. MOTHER'S MAIDEN NAME Matilda Krebs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes (If yes, give war or dates of service) I'll

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Wm Gable (Gable) ADDRESS 724 E. 20th St Balto. 18

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction -
DUE TO
(B) A.S.C.V.D.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-3-49, 19__, *to* 6-21-49, 19__, *that I last saw the deceased alive on* 6-21-49, 19__, *and that death occurred at* 1:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Bowie Lynn Grant M. D. | 23B. ADDRESS West. Baltimore Gen Hosp. | 23C. DATE SIGNED 6-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/24/49	Lutheran	Glen Rock, Pa.

DATE RECEIVED BY LOCAL REGISTRAR JUN 22 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Geo C Gepfe ADDRESS Glen Rock, Pa.

VS 150

93D

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G75534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75534 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELIZABETH PARSONS

2. DATE OF DEATH: JUNE 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2908 Chesley Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 27 E Wheeling St. 73-0Y

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: MARCH 12, 1869
9. AGE (In years last birthday): 80 — If under 1 Year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BENJAMIN DAVIS
14. MOTHER'S MAIDEN NAME: RACHEL MEEKINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT: ANNA NOLKER — ADDRESS: 2908 Chesley Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
(B) Arteriosclerotic Heart Disease — 5 years
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 5, 1949, *to* June 19, 1949, *that I last saw the deceased alive on* June 18, 1949, *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: George Sawyer, M. D.
23B. ADDRESS: 4808 Harford Rd.
23C. DATE SIGNED: 6/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/22/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Taylor Ave, City

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John F. Denny, Inc. — ADDRESS

VS 150

937

Please write the cause of death clearly and fully. Physician's collect age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

45 0 ✓ X

Registered No. ~~B75535~~

B75535

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH WHITNEY SHIRLEY

2. DATE OF DEATH: 6-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md.
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~BALTIMORE~~ REISTERTOWN
D. STREET ADDRESS (If rural, give location): Main Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Widower	3-12-1871	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Civil Engineer	MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Clay Shirley	KATHERINE DAVIDSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes Spanish-American	None	(SON) JOSEPH W. SHIRLEY	REISTERTOWN

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	CONGESTIVE FAILURE (RLG)	7 yrs
DUE TO (B)	GENERALIZED Arteriosclerosis	
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Paralytic ilius	6 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [A] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* JUNE 4 1949 *to* JUNE 20, 1949, *that I last saw the deceased alive on* JUNE 20, 1949, *and that death occurred at* 12:05 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. F. Coy 3d M.D.	UNION MEMORIAL HOSP.	6-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 22 1949	Greenmount	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 22 1949	Huntington Williams, M.D.	Stewart & Mowen Co.	155 W. North Ave

VS 150

122 B Baltimore 7, Md

Please write clearly and legibly. Physician: please write the cause of death, correct age is especially important.

G75536

BIRTH NO. G75536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75536

1. NAME OF DECEASED (Type or Print): William C. Reely

2. DATE OF DEATH: June 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital DOA
c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 2916 Georgetown Rd 25-52

5. SEX: M.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 20th 1881
9. AGE (In years last birthday): 68
If Under 1 Year: Months: 1 Days: 3
If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Freight Conductor
10B. KIND OF BUSINESS OR INDUSTRY: Pa. R. R.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Artemus Reely
14. MOTHER'S MAIDEN NAME: Anna Hamilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. D. M. Reely
ADDRESS: 2916 Georgetown Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: William G Helfrich M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: June 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/24/49
24C. NAME OF CEMETERY OR CREMATORY: Meadow Ridge
24D. LOCATION (City, town or county) (State): Dorsey Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc.
ADDRESS: 527 St. Paul St.

VS 151

94a

Please write the cause of death clearly and legibly. Physician: please write the correct age in especially important.

G75537

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 17

G75537

Registered No.

1. NAME OF DECEASED (Type or Print): Mary Frazier

2. DATE OF DEATH: 6/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2815 Washington Blvd

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 25-5-52
D. STREET ADDRESS (If rural, give location): 2815 Washington Blvd

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov 10 1879
9. AGE (In years last birthday): 69 — If Under 1 Year: Months 7, Days 9; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Schramm
14. MOTHER'S MAIDEN NAME: Anna Maria Weidenman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: James Frazier — ADDRESS: 337 E. Hamburg St

MEDICAL CERTIFICATION

(Please write the cause of death clearly. Physician: please write important, especially correct age is especially important.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion Dec 1948

DUE TO: c Metastases

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: Dec 1948
19B. MAJOR FINDINGS OF OPERATION: Coronary thrombosis
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 6, 1948, to Jun 19, 1949 *that I last saw the deceased alive on* Jun 19, 19 49 *and that death occurred at* 7:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Irvin H. Lee Sherman M. D.
23B. ADDRESS: 3426 Bank St
23C. DATE SIGNED: Jun 20 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/22/49
24C. NAME OF CEMETERY OR CREMATORY: Western
24D. LOCATION (City, town or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 72 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. — ADDRESS: 1217 St. Paul St.

49a

G75538

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75538

1. NAME OF DECEASED (Type or Print): WALKER, ANNA

2. DATE OF DEATH: June 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 200 Hilltop Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	Sept 24, 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Maryland	

13. FATHER'S NAME: James Willis

14. MOTHER'S MAIDEN NAME: Louise Pitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Records — ADDRESS: Franklin Square Hospital

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Myocardial Infarction	8 days.
DUE TO (B)	Coronary Sclerosis	yrs
DUE TO (C)	Hypertensive CV Disease	yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 6-12, 1949 *to* 6-20, 1949 *that I last saw the deceased alive on* 6-20, 1949, *and that death occurred at* 7:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. J. Lalam, M. D.	Franklin Sq Hosp	

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	6/24/49	Cedar Hill	U.A.Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 22 1949	Huntington Williams, MD	Wm Cook Inc.	127 St. Paul St.

VS 150

93D

VS-127334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

150 G75539 Registered No.

75539

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John J. Brannan

2. DATE OF DEATH 6-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospitals

c. Length of stay in Baltimore 62 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 420 E. Biddle Street. 10-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Wid.	March 18, 1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Pa. Lancaster

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Deceased

14. MOTHER'S MAIDEN NAME Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 717-07-8140

17. INFORMANT RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Carcinoma of Esophagus — 5 mos

DUE TO

(C) — 1

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES Yes NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-5- 1949 *to* 6-21 1949, *that I last saw the deceased alive on* 6-21 1949 *and that death occurred at* 4:15 A. *from the causes and on the date stated above.*

23A. SIGNATURE J. S. Horgan M. D.

23B. ADDRESS 4940 Eastern Avenue

23C. DATE SIGNED 6-21-49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify) Burial

24B. DATE 6/23/49

24C. NAME OF CEMETERY ~~OR CREMATORY~~ Cathedral

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 22 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm Cook Inc.

ADDRESS 1217 St. Paul St

VS 150

Yes

46a

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G75540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G75540

1. NAME OF DECEASED (Type or Print) Charles E. Rockwell

2. DATE OF DEATH 6-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital

c. Length of stay in Baltimore 5 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Washington
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Williamsport
D. STREET ADDRESS (If rural, give location) 37 Fenton Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	Married	2 Feb 1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Thomas Rockwell
14. MOTHER'S MAIDEN NAME Cary Sinclair
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Shock, Post Operative Auricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Resection & Recto-sigmoid for carcinoma

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coronary Sclerosis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-21-49	Carcinoma Rectum	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 6-16-49 19 , to 6-21-49 19 , that I last saw the deceased alive on 6-21-49 19 , and that death occurred at 6:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T. Lacy Morrow M. D.	Church Home & Hospital	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 24-49	Riverview	Williamsport Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 22 1949	Huntington Williams, M.D.	Leaf Funeral Home Edith V. Leaf	Williamsport Md.

VS 150

46D

Please write the cause of death clearly and legibly. Physician: please write the correct age in years. Any information not known to you, but important, please state.

BIRTH NO. 675541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 675541

1. NAME OF DECEASED (Type or Print): William Edward Williams

2. DATE OF DEATH: June 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 823 Williams St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 823 William St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	divorced	Oct. 22 1907	41				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
mutual clerk	race tracks	Maryland	U.S.A.

13. FATHER'S NAME: Thomas A. Williams

14. MOTHER'S MAIDEN NAME: Katherine McCormick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		212-09-4340	Thomas A. Williams	823 William St.

MEDICAL CERTIFICATION

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 2

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Myocardial Degeneration

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 12, 1949, to June 19, 1949, *that I last saw the deceased alive on* June 18, 1949, *and that death occurred at* 9:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Schemmel M. D.	1337 S. Charles St.	6/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June22,1949	New Cathedral	Old Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Krause Funeral Home

ADDRESS: 1216 S. Charles St

VS 150

13B

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-20-1 G75542 Registered No.

5542 BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edgar Otis McAbee

2. DATE OF DEATH: 20 June 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 602 Glenolden Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 602 Glenolden Ave. 16-06

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1/7/1878
9. AGE (In years last birthday): 71 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lineman (Retired)
10B. KIND OF BUSINESS OR INDUSTRY: B & O Railroad
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles W. Mc Abee
14. MOTHER'S MAIDEN NAME: Laura V. Giggis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 705.05.6633
17. INFORMANT: Mrs. Anna McAbee ADDRESS: 602 Glenolden Av.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer, D. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 20 June 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/23/49
24C. NAME OF CEMETERY OR CREMATORY: Western
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. T. Stansbury ADDRESS: 2700 Edmondson Ave

VS 151

94a

G75543
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 9720 G75543
Registered No.

1. NAME OF DECEASED (Type or Print) FREDERICK DANGELIET N-968
2. DATE OF DEATH 6/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2519 Barclay St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore 48 — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 2519 Barclay St. 12-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Jan. 13th 1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker	Retail Bakery	Germany	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frederick Dangeliet	Louise Zimmerman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		217-16-3614	Paul F. Kaufman	2430 Plummond

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Asphyxiation	
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) illuminating gas	
	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2519 Barclay St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) June 19, 1949 ? m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Hose from gas burner to mouth (Burner Illuminating gas on but unlit)

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE John R Davis M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED 6/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/22/49	Trinity	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 22 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR E. J. Fanning ADDRESS 1938 E. Lafayette Ave.

VS 151

163H

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

KRAEMER

G75544

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75544

1. NAME OF DECEASED (Type or Print): DAVID A. KRAEMER

2. DATE OF DEATH: 6-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale Home
c. Length of stay in Baltimore: 60 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2410 Keyworth Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widower	1873	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None* Tailor		Russia	

13. FATHER'S NAME: Jacob Kraemer

14. MOTHER'S MAIDEN NAME: Rebecca Samuelson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Jacob Kraemer	2410 Keyworth Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4-1 *19* 49 *to* 6-21 *, 19* 49 *that I last saw the deceased alive on* 6-21 *, 19* 49 *and that death occurred at* 5:20 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Nagel M. D.	Levindale Home	6-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 22, 1949	Hebrew "ashington Rd Cem	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 22 1949	Huntington Williams, M.D.	Sol Levinson & Bros	1124 W North Ave

VS 150

83a

Do not use this space. Important. Physician please write plainly.

G75545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1

Registered No. G75545

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary A. Seipp

2. DATE OF DEATH June 21-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 635 Bartlett Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
635 Bartlett Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 9-08
D. STREET ADDRESS (If rural, give location) 635 Bartlett Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	May 3-1884	65	1	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Balto.	

13. FATHER'S NAME John Kenney

14. MOTHER'S MAIDEN NAME Mary Radigan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Arthur G. Seipp — ADDRESS: 635 Bartlett Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1-Mo.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* MAY 15, 19 49, *to* JUNE 21, 19 49, *that I last saw the deceased alive on* JUNE 20, 19 49, *and that death occurred at* 2 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Norman R Kleiman M. D.	3803 Edmondson Ave	6/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 24-49	Lorraine Cem.	Windsor Mill Rd. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 22 1949	Carrington Williams, M.D.	John A. Miller	2334 Jefferson St.

VS 150

94a

correct age is especially important. Payment, please write this

G75546

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1949

G75546

Registered No.

1. NAME OF DECEASED (Type or Print): Henry P. Wischhusen

2. DATE OF DEATH: June 21-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4506 Parkmont Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 21 01
D. STREET ADDRESS (If rural, give location): 4506 Parkmont Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Dec. 8-1893	55	6 / 13	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Bethlehem Steel Co.	Balto.	U.S.

13. FATHER'S NAME: Dietrich Wischhusen

14. MOTHER'S MAIDEN NAME: Dorothea Ahlers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	087-10-5202	Estelle V. Wischhusen	4506 Parkmont Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brain Tumor,
DUE TO
(B) Glioblastoma of temporal lobe
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 19, 1949 *to* June 21, 1949 *that I last saw the deceased alive on* June 20, 1949 *and that death occurred at* 11:10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Adam Stevens M. D.	6232 Belair Rd	June 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, county) (State)
Burial	June 24-49	Bal. Lawn Cem.	Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 22 1949	Lurington Williams, M.D.	John A. Miller	2334 Jefferson St

VS 150

54a

Please write clearly and correct age is especially important. Physician, please write the cause of death plainly and fully.

G75547
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75547

1. NAME OF DECEASED (Type or Print): HYMAN BROTMAN
2. DATE OF DEATH: 6-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3710 Leistertown Rd
C. Length of stay in Baltimore: 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3710 Leistertown Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married		66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Kopel
14. MOTHER'S MAIDEN NAME: Gaila
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Sarah Brotman ADDRESS: 3710 Leist Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — Interval between onset and death: 8 hrs
DUE TO
(B) Coronary artery disease, Arterio Sclerosis — 1 year, 15 years
DUE TO
(C) Emphysema + Bronchitis — 10 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐	NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 20 1940, to June 21, 1949, that I last saw the deceased alive on June 21, 1949, and that death occurred at 4 30 p m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jack Cohen, M. D.	1804 Eutaw Place	6/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-22-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 22 1949	Huntington Williams, M.D.	Jack Lewis & Son	2100 Eutaw Pl

VS 150

Write the cause of death clearly and legibly. Physician, please write the correct age is especially important.

94a

G75548 (1) BALTIMORE CITY HEALTH DEPARTMENT 416 G75548

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Alice Ginsburg

2. DATE OF DEATH: 6-21-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 27-16
D. STREET ADDRESS (If rural, give location): 2576 Cold Spring Lane #15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	9-2-05	94		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cashier	Wyman's Shoe Store	Mass.	USA

13. FATHER'S NAME: Benjamin

14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Bessye Ginsburg	2576 Cold Spring La

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aortic stenosis + insufficiency — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rheumatic Cardiovascular Disease

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Agitated Psychosis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-14-49, 19__, *to* 6-21-49, 19__, *that I last saw the deceased alive on* 6-21-49, 19__, *and that death occurred at* 325 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Boure Lon. Gardner M. D.	West Baltimore Gen. Hosp	6-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-23-49	Hebrew Friendship	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 22 1949	Huntington Williams, M.D.	Jack Reives Jr	2100 Eutaw Pl

VS 150

92a.

correct age is especially important. Physicians please write the cause of death clearly and legibly.

G75549
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75549
Registered No.

1. NAME OF DECEASED (Type or Print) George Tucker

2. DATE OF DEATH 6/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Balt
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-04
D. STREET ADDRESS (If rural, give location) 1031 Tiffany Alley

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Married		60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
			USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 20, 1949, *to* June 20, 1949, *that I last saw the deceased alive on* June 20, 1949, *and that death occurred at* 10:45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank E Brunback M. D.	University Hosp	6/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/25/49	Mt. Calvary	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 22 1949	Huntington Williams, M.D.	Metropolitan Funeral Home Inc. 927 N. Mount St.

VS 150

83a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

75550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75550

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James R. Bishop

2. DATE OF DEATH: 6/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto City Hospital
C. Length of stay in Baltimore: 33yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
821 S. Kenwood Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md. 1-01
D. STREET ADDRESS (If rural, give location): 821 S Kenwood Ave

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar. 17/1893
9. AGE (In years last birthday): 56 (If Under 1 Year: Months, Days; If Under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elevator Operator
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Bishop
14. MOTHER'S MAIDEN NAME: Nancy Stephens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): W.W.1
16. SOCIAL SECURITY NO.: 213-03-6494

17. INFORMANT — ADDRESS: Mrs. Ethel C. Bishop, 821 S. Kenwood Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Disease	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: C. P. Zubrinsky M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 6/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 25/49
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cem
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Philip Sterling Sons
ADDRESS: 2024 Orleans St.

VS 151

94a

correct age is especially important. Physicians: please write the cause of death clearly and accurately.

75551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 75551

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNA KATHERINE DIMLING

2. DATE OF DEATH: June 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 510 Woodside Rd., Ten Hills
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 510 Woodside Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	single	July 30, 1871	77 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Dimling
14. MOTHER'S MAIDEN NAME: Anna Katherine
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Matilda Marie King
ADDRESS: 510 Woodside Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE, OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocarditis
DUE TO
(B) Cardio Vascular Renal Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 1945 *to* June 19, 1949 *that I last saw the deceased alive on* June 19, 1949, *and that death occurred at* 2:30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Walter H. Leavitt M. D.
23B. ADDRESS: 4709 Fredinda Ave
23C. DATE SIGNED: 6/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/22/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

48-150

121a

Please write the cause of death clearly and correctly. Physician: please write correct age in especially important.

G75552

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 p. 1

Registered No. G75552

1. NAME OF DECEASED (Type or Print): MATHILDA C. BRUENING

2. DATE OF DEATH: June 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4413 Sedwick Rd.

c. Length of stay in Baltimore: Yrs. Mos. Days.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4413 Sedwick Rd. 22-14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	widow	Aug. 31, 1877	71 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Pittsburgh, Pa.	

13. FATHER'S NAME: * John Hermann

14. MOTHER'S MAIDEN NAME: - Margaret ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		no

17. INFORMANT: Mr. Richard Qu. Yardley ADDRESS: 4413 Sedwick Rd.

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 0

DUE TO

(B) Hypertensive cardiovascular disease — About 3 Yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1946, *to* June 20, 1949, *that I last saw the deceased alive on* June 16, 1949, *and that death occurred at* 3:20 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Howard B. Barr, M. D.	516 Cathedral St.	6-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	6/22/49	Homewood Cem.	Pittsburgh, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 22 1949	Thurlington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

S 456

93D

G75553 BIRTH NO. B.C. 48-26588

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75553

1. NAME OF DECEASED (Type or Print): Joyce Barber

2. DATE OF DEATH: June 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1027 N. Stricker

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C		Dec. 9, 1948		6 / 11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Barber
14. MOTHER'S MAIDEN NAME: Betty Gantt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Betty Gantt ADDRESS: 1027 N. Stricker St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uppe Respiratory Infection
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Paul Ross M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: June 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 22, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Kate R. Williams Schroeder
ADDRESS: 3224

VS 151

1042

G75554

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

143 G75554
Registered No.

1. NAME OF DECEASED (Type or Print) Carrie Hayes

2. DATE OF DEATH 6-18-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2239 N. Calhoun St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN Balto. (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 2239 N. Calhoun St. 19

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	Col.	Married	5-6-1911	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Accomac Co Va.	

13. FATHER'S NAME Henry Parker

14. MOTHER'S MAIDEN NAME Eleanor Finney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		Elnora Parker	2239 N. Calhoun St

MEDICAL CERTIFICATION

(Physician: please write the cause of death clearly and accurately. Correct age is especial important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 6-18-49
DUE TO
(B) Hypertension — 3 months
DUE TO
(C) Hypertensive Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 19 49 *to* June 18, 19 49 *that I last saw the deceased alive on* June 18 19 49, *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr. Wm. J. Higgins M. D.	2243 Madison Ave	6-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 22, 1949	Arbutus Memorial Park	Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 22 1949

REGISTRAR'S SIGNATURE Thomas Williams, M.R.

25. FUNERAL DIRECTOR Mrs Katie R. Williams ADDRESS 3224 Edmondson Ave

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G755555 Registered No.

G755555 BIRTH NO.

1. NAME OF DECEASED (Type or Print): HENRY OHMS

2. DATE OF DEATH: 6-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

c. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore #21
D. STREET ADDRESS (If rural, give location): 809 George Ave. 1103

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: January 9, 1865
9. AGE (In years last birthday): 84
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Boats, Load Repair
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: H. Zoellner ADDRESS: CH+H

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarction — 2 wks
DUE TO
(B) Arteriosclerotic heart disease
DUE TO
(C) Generalized arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/19, 1949, to 6/20, 1949, *that I last saw the deceased alive on* 6/19, 1949, *and that death occurred at* 1:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Donald W. Munn M. D.
23B. ADDRESS: Church Home + Hosp.
23C. DATE SIGNED: 6/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 23-49
24C. NAME OF CEMETERY OR CREMATORY: Western Cem.
24D. LOCATION (City, Town, or County) (State): Edmonson Ave Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John F. Connelly
ADDRESS: Essex

VS 150

93D

Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

G75556

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75556

Registered No.

1. NAME OF DECEASED (Type or Print): Mary A Eutajar

2. DATE OF DEATH: 6/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 813 Hollins St.

c. Length of stay in Baltimore: Life (Yrs. / Mon. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 813 Hollins St. 18 53

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 10/1/1883
9. AGE (In years last birthday): 65 66 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Tibbels

14. MOTHER'S MAIDEN NAME: Emma Sloane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Miss Mary Eutajar ADDRESS: 813 Hollins St.

MEDICAL CERTIFICATION

(To be filled in by physician. Please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and correct age is especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 Minutes
DUE TO
(B) Arteriosclerotic Heart Disease — Unknown
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 22, 1948 to June 21, 1949, that I last saw the deceased alive on June 20, 1949, and that death occurred at 2.00 P m., from the causes and on the date stated above.

23A. SIGNATURE: Nathan Ravvin M. D.
23B. ADDRESS: 206 S Gilmor St
23C. DATE SIGNED: 6.22.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/24/49
24C. NAME OF CEMETERY OR CREMATORY: Louden Park Cem
24D. LOCATION (City, town, or county) (State): 3801 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: 937 Hollins St

G75557

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 171

G75557

Registered No.

1. NAME OF DECEASED (Type or Print): LETITIA WILLIAMS

2. DATE OF DEATH: 6-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

c. Length of stay in Baltimore: 17 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Reisterstown
D. STREET ADDRESS (If rural, give location): All Saints Church Rectory

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	April 11, 1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper	Church Rectory	Maryland	USA

13. FATHER'S NAME: William Lewis

14. MOTHER'S MAIDEN NAME: Martha Von Groca

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		A. Grahe	Church Home and Hospital

MEDICAL CERTIFICATION

(Please write clearly and use ink. Physician: please write the cause of death clearly and correct age is especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal Obstruction

DUE TO

(B) Carcinoma of Cervix

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1943	Carcinoma of Cervix	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-6, 1949, *to* 6-22, 1949, *that I last saw the deceased alive on* 6-22, 1949, *and that death occurred at* 3:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lucy Morrow M. D.	Church Home & Hosp.	6-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 25, 1949	All Saints Cem.	Reisterstown, Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 22 1949	Huntington Williams, M.D.	E. J. Ebaugh	Reisterstown, Md.

VS 150

48a

75558

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G25558

Registered No. 233124

1. NAME OF DECEASED (Type or Print) Sister Rosalie Dorschel

2. DATE OF DEATH 6-22-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 3 Md
D. STREET ADDRESS (If rural, give location) 901 Augusta St 10-02

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single

8. DATE OF BIRTH June 29 1871

9. AGE (In years last birthday) 77 78

If Under 1 Year: Months, Days

If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Pittsburgh Pa

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Stephen Dorschel

14. MOTHER'S MAIDEN NAME Catherine Schwendenwein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. No

17. INFORMANT — ADDRESS Mother Sis M Magdalen

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic CV disease —

DUE TO

(B) Gangrene left foot & leg - mid thigh amputation

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 6/2/49

19B. MAJOR FINDINGS OF OPERATION Thrombosis popliteal artery - Arteriosclerosis - Gangrene

19C. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/31 1949 to 6/22 1949 that I last saw the deceased alive on 6/21 1949, and that death occurred at 1:10 Amr from the causes and on the date stated above.

23A. SIGNATURE Frank O'Dwyer Jr M.D.

23B. ADDRESS St Agnes Hosp

23C. DATE SIGNED 6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE June 24 49

24C. NAME OF CEMETERY OR CREMATORY Notch Cliff

24D. LOCATION (City, town, or county) (State) Glen Arm

DATE RECEIVED BY LOCAL REGISTRAR JUN 22 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS Geo M. Frisk & Son

VS 155

93D

correct age is especially important. Physician: please write the cause of death clearly and fully.

G75559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Reg. No. 19 G75559

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Daisy D. Albright

2. DATE OF DEATH June 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5512 Mattfeldt Avenue

c. Length of stay in Baltimore 60 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 5512 Mattfeldt Avenue 2-7-15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	May 8, 1871	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Virginia	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Sarah Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	---	Miss Lucy D. Albright	5512 Mattfeldt Ave.

MEDICAL CERTIFICATION

Physician: please write the cause of death clearly and correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Coronary sclerosis
DUE TO
(C) age

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1, 1949, *to* June 19, 1949, *that I last saw the deceased alive on* June 19, 1949, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sherman R. Mantz M. D.	2601 Maryland Ave.	6/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 22, 1949	Woodlawn	Baltimore Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 22 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

94a

F

G75560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E981.5 G75560

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DOCK WOOLEY — N-862.4

2. DATE OF DEATH June 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital (doa)

C. Length of stay in Baltimore 26 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 515 North Central Avenue S-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	colored	married	3-8-1897	52				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Operator of lunch room
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Estway N. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Benjamin F Woolley
14. MOTHER'S MAIDEN NAME Annie Burton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) World War #1
16. SOCIAL SECURITY NO. 216-25-1149
17. INFORMANT Nannie Wooley ADDRESS 1645 Madison St.

MEDICAL CERTIFICATION

(Write the cause of death clearly and legibly. Physician: please write correct age is especially important.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet wounds

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chest & Abdomen

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) H Alley alongside 515 N. Central Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) June 19, 1949 10p.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? firearms

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE Earl K Royer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED June 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Shipe	6/22/49	Seds Grove	Edgewood Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 22 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR 1532 Bidd St ADDRESS St.
Randolph J. Wollock

VS 151

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G75561

BIRTH NO. G75561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Hunter O. English — HUNTER O. ENGLISH

2. DATE OF DEATH: June 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: Dorchester
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hurlock
D. STREET ADDRESS (If rural, give location): R.F.D. #1

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 8-10-03
9. AGE (In years last birthday): 45. If under 1 year: Months, Days. If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Refrigerator Engineer
10B. KIND OF BUSINESS OR INDUSTRY: Refrig. Corp.

11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wesley English

14. MOTHER'S MAIDEN NAME: Virginia Treney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 173-03-1828

17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lymphoma, Tyler undetermined manifested by fever

DUE TO (B)

DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-8, 1949 *to* 6-21, 1949, *that I last saw the deceased alive on* 6-21, 1949, *and that death occurred at* 3.50 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard S. Ross, M.D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 6.21.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 23 June 49
24C. NAME OF CEMETERY OR CREMATORY: Forrest Oak Cemetery
24D. LOCATION (City, town, or county) (State): Gaithersburg Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: ROBERT PUMPHREY
ADDRESS: Bethesda Md.

VS 150

57E

Make the Cause of Death entry clearly and legibly. Physician: please write the correct age in especially important.

To Be approved by Dr. Helfrich Medical Examiner

G75562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

BIRTH NO. | Registered No. G75562

1. NAME OF DECEASED (Type or Print): Annie Willner

2. DATE OF DEATH: June 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland MGH

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 109 W Corky St Apt 24 (109 N Carey St.) 6-01

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12-23-1890
9. AGE (In years last birthday): 58 59
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. W.
10B. KIND OF BUSINESS OR INDUSTRY: House wife
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: John Long
14. MOTHER'S MAIDEN NAME: Mary Baum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Fredrick Husband
ADDRESS: As above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Extensive subarachnoid hemmorhage — Interval between onset and death: 9 hrs
DUE TO
(B) Hyper Tensive cardiovascular disease — 5-10 yrs
DUE TO
(C) Numerous contusions pre-dominantly left temporal area and left forearm & thigh — 9 hrs
Cardiac hypertrophy Bilateral phlebothrombosis right varicose ulcer — 4-5 yrs
Hepatomegaly splenomegaly cpl cirrhosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

W. G. Helfrich M.D.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 109 W. Corky Street (109 N. Carey St.)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: June 20, 1949 10a m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Collapsed and fell down stair steps 6-01

22. *I hereby certify that I attended the deceased from* June 20, 1949 *to* June 20, 1949 *that I last saw the deceased alive on* June 20, 1949, *and that death occurred at* 6.45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Marguerite Louise Candler pending MA approval
23B. ADDRESS: Md Gen'l Hosp
23C. DATE SIGNED: 6-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-24-49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Taylor Ave

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Courtesy for Williams, M.D.
25. FUNERAL DIRECTOR: John C. Moran
ADDRESS: 3000 E Baltimore St

VS 150

N.B. No evidence of fractures

1860

Please write the entire, correct age in years. Physician's special, important.

G75563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E974 G75563 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John E. Brennan N-991

2. DATE OF DEATH: June 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: 30 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, last residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5608 Winthrope Ave. 27-44

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
M	W	Widowed	April 20th 1893	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter		Woodbury N.J.	U.S.

13. FATHER'S NAME: Peter G. Evan
14. MOTHER'S MAIDEN NAME: Margaret Meister

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	217-16-5445	Mrs Brennan 5608 Winthrop Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation
DUE TO
(B) Hanging
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Cellar of home 5608 Winthrope Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 21, 1949 abt. 7 A.M.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Hanged self by clothesline rope

22. *I certify that I took charge of the remains described above, held an* Insp. & In. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

23A. SIGNATURE: Carl L Evan M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: June 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 23rd 1949	Baltimore National	Fredrick Road

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR: John Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Leo E. Cook 1703 N. Patterson Park Ave

164a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

VS 151

G75564 ✓ G75564

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
4 v 0 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Pleiss, William H.

2. DATE OF DEATH: 6-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp
C. Length of stay in Baltimore: 65 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-2
D. STREET ADDRESS (If rural, give location): 1018 Druid Hill Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 24, 1881
9. AGE (In years last birthday): 68 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery Store Keeper
10B. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William D. Pleiss
14. MOTHER'S MAIDEN NAME: Caroline Wienecke
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Anna E. Pleiss ADDRESS: 1018 Druid Hill Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Bronchio pneumonia
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-18 —, 1949 *to* 6-21 —, 1949, *that I last saw the deceased alive on* 6-21 —, 1949, *and that death occurred at* 5:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: William F. Haun, M.D.
23B. ADDRESS: So. Balti. Gen Hosp., Balti 30 Md
23C. DATE SIGNED: 6-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 24/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town, or county) (State): Balto Co

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mr. & Mrs. John H. Templeton
ADDRESS: 5311 93D Edmondson Ave

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G75565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75565 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (MIKE MILLER) NICHAL CZENSKI

2. DATE OF DEATH June 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
City Jail

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mount Carmel
D. STREET ADDRESS (If rural, give location) 337 South Beech Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white		1904	45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Mt Carmell Penn	USA.

13. FATHER'S NAME
Anthony Ozenski

14. MOTHER'S MAIDEN NAME
Rose Fritz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Thomas Koons	Mt Carmel Pa

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Important: Physician's correct age is especially desired.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Edema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Chronic Alcoholism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Royer M.D.		June 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	June 30/49	St. Mary's	Mt Carmel Penn.

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Geo W Fackenthal — ADDRESS: 703 McKean Ave

VS 151

77D

G75566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 143

G75566 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Virginia (Dufford) Moorman

2. DATE OF DEATH: June 18 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: 16 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 8-7
D. STREET ADDRESS (If rural, give location): 1933 E. Biddle St

5. SEX: F
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 29 1906
9. AGE (In years last birthday): 42 43
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk-Lent Cleaner
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wayatt Barker
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Virginia Moorman ADDRESS: 1933 E Bid

MEDICAL CERTIFICATION

correct age is especially important. Physician: please write the causes of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Hypertensive C. V. Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl L Kaylor M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 19 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 23/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem.
24D. LOCATION (City, town, or county) (State): B.C. County Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Custodian for Baltimore, Md
25. FUNERAL DIRECTOR: Wm. Scott G. Elliott & Daughter ADDRESS: 937 N. Carlton St

VS 151

G75567 ✓ G75567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 344

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): SOPHIE MEREDITH BOYCE ?

2. DATE OF DEATH: 6-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore: 32yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 4102 GREENWAY 12-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	S	6-10-17	32yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRED G. BOYCE, JR.
14. MOTHER'S MAIDEN NAME: SOPHIE MEREDITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: PARENTS ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) FALL ON HEAD — INTERVAL BETWEEN ONSET AND DEATH: 11 days.

DUE TO

(B) MENTAL DISEASE - ARRESTED HYDROCEPHALOUS.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
for DR. J. R. DAVIS
M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Hospital
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Sheppard Pratt, Towson, Md.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 11, 1949 ? m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Slipped & Went into convulsion-fell down steps

22. *I hereby certify that I attended the deceased from* JUNE 11 1949 *to* JUNE 22, 1949, *that I last saw the deceased alive on* JUNE 22, 1949 *and that death occurred at* 4 P.M. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Francis J. Cattin M. D.
23B. ADDRESS: Union Memorial Hosp.
23C. DATE SIGNED: 6-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: June 23/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Contagion Witness, M.D.
25. FUNERAL DIRECTOR: Henry N. Jenkins & Sons ADDRESS: 4905 York Rd.

VS 150

186a

correct age is especially important. Physician: please write the cause of death clearly.

✓ G75568

G75568

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1949 8

Registered No.

1. NAME OF DECEASED (Type or Print): Mr. Ole Martin Jansen

2. DATE OF DEATH: June 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

C. Length of stay in Baltimore: 10yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 817 McCabe Avenue 27-10

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 18, 1886
9. AGE (In years last birthday): 62 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10B. KIND OF BUSINESS OR INDUSTRY: Own Business

11. BIRTHPLACE (State or foreign country): Minn.
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Ludwig Jansen

14. MOTHER'S MAIDEN NAME: Olga Hay

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Karen Jansen ADDRESS: 817 McCabe Ave.

MEDICAL CERTIFICATION

Please write the CAUSE OF DEATH clearly and legibly. Physician: please write correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/12/ , 1949 *to* 6/21/ , 1949 *that I last saw the deceased alive on* 6/21/ , 1949 *and that death occurred at* 11:50 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: William R. Beckam M. D.

23B. ADDRESS: 1400 N. Caroline Street

23C. DATE SIGNED: 6/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 6-17-1949

24C. NAME OF CEMETERY OR CREMATORY: Arlington

24D. LOCATION (City, town, or county) (State): Drexel Hill, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949

REGISTRAR'S SIGNATURE: Thomas [illegible] Hillsville, Md.

25. FUNERAL DIRECTOR ADDRESS: H. W. Jenkins & Sons C. 4905 York Rd.

VS 150

55E

G75569 ✓ G75569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH Dr. No. 1

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VIRGINIA C. HEINEKAMP

2. DATE OF DEATH June 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3118 Ferndale ave.

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-2
D. STREET ADDRESS (If rural, give location) Hopkins Apts. St. Paul at 31st street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	Married	Sept. 4. 1895	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home	---	Baltimore, Md.	U.S.A.

13. FATHER'S NAME
Dr. Theodore Cooke, Jr.

14. MOTHER'S MAIDEN NAME
Mae E. Clarke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	none	Mr. Joseph Heinekamp Hopkins Apts.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
DUE TO
(B) Occluding Coronary — Unknown
DUE TO
(C) Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 15, 1949 *to* June 20, 1949, *that I last saw the deceased alive on* June 20 1949, *and that death occurred at* 7:30 p. m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles R. Goodbody M. D.	2923 St Paul St	6/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/23/49	Druid Ridge	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Chas. G. Evans & Son Inc. ADDRESS: 118 N. Mt. Royal Ave 94a

VS 150

Correct age is especially important. Physician: please write plainly.

G75570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

754 ° G75570 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Karen Sue Evans

2. DATE OF DEATH: June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Surg. Hal 3

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Alleg.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Westernport
D. STREET ADDRESS (If rural, give location) /

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: 11-22-47
9. AGE (In years last birthday): 1 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): W. Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard Evans

14. MOTHER'S MAIDEN NAME: Christine Wright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema
DUE TO
(B) Cardiac failure
DUE TO
(C) Congen. heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 6/17/49
19B. MAJOR FINDINGS OF OPERATION: Patent D. Botalli
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): /
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-19-, 1949, to 6-22-, 1949, *that I last saw the deceased alive on* 6-22-1949, *and that death occurred at* 9:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. C. Smith M.D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Philos Cemetery
24D. LOCATION (City, town, or county) (State): Westernport Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles F. Friend & Son Inc
ADDRESS: 118 N. Mt. Royal Ave

VS 150

157E

Please write clearly. Physician: Correct age is especially important.

G75571 ✓ G75571

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

Registered No.

1. NAME OF DECEASED (Type or Print): Loretta E. Rooney

2. DATE OF DEATH: June 21 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1800 N Baroline St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1800 N. Caroline St.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 9-9
D. STREET ADDRESS (If rural, give location): 1800 N Baroline St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: May 30 1900
9. AGE (In years last birthday): 49
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Rose Crossan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Marian D. Dunn ADDRESS: 426 Overbrook Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) hypertension — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEAYH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Auricular fibrillation — 3 yrs

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 19 1946 *to* June 4 1949, *that I last saw the deceased alive on* June 20 1949, *and that death occurred at* 4:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: S. Lubofsky M. D.
23B. ADDRESS: 714 E. Preston St
23C. DATE SIGNED: June 22

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 23 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Old Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: John C. Moran ADDRESS: 3000 E. Baltimore St

VS 150

832

Schoelkopf

G75572 BIRTH NO. B.C.49-11547 Schoelkopf

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

776 Registered No. G75572

1. NAME OF DECEASED (Type or Print): Baby Boy Schoelkopf

2. DATE OF DEATH: 6/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Catonsville
D. STREET ADDRESS (If rural, give location): 1301 Summit Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	single	6/4/49			35

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Hubert E. Schoelkopf
14. MOTHER'S MAIDEN NAME: Clara Luber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 35 Min.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-30 *to* 6/4/49, 19__, *that I last saw the deceased alive on* 6/4/49, 19__, *and that death occurred at* 9 a m., *from the causes and on the date stated above.*

23. SIGNATURE: Sylvester Fortuni A. M.D.
23A. ADDRESS: 2706 St Paul St
23C. DATE SIGNED: 6/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/6/49
24C. NAME OF CEMETERY OR CREMATORY: Forrians Park
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 22 1949
REGISTRAR'S SIGNATURE: Hunter Williams, M.D.
25. FUNERAL DIRECTOR: Burger Funeral Home
ADDRESS: 3631 Falls Rd.

VS 150

OVER

159

G755573

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G755573

1. NAME OF DECEASED (Type or Print): Charles Blackmelder

2. DATE OF DEATH: June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days: 1 day

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Charles
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Waldorf
D. STREET ADDRESS (If rural, give location):

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 5-17-84
9. AGE (In years last birthday): 65 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Blackmelder
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ?
(If yes, give war or dates of service): ?
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral vascular accident & Circulatory Collapse — INTERVAL BETWEEN ONSET AND DEATH: 10-12 hrs

DUE TO

(B) Arteriosclerotic Cardiovascular disease — 5-6 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Urinary Retention — 2-3 yrs.

19A. DATE OF OPERATION: 6/22/49
19B. MAJOR FINDINGS OF OPERATION: Urethral Strictures and contracted vesical neck
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-21, 1949, *to* 6-22, 1949, *that I last saw the deceased alive on* 6-22, 1949, *and that death occurred at* 6 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: William E. Chase M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 6/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/25/49
24C. NAME OF CEMETERY OR CREMATORY: Okland Cem
24D. LOCATION (City, town, or county) (State): Waldorf Md
ADDRESS:

DATE RECEIVED BY LOCAL REGISTRAR: JUN 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Hewitt + Reyon Waldorf Md

VS 150

136a

correct age is especially important. Physicians: please write the cause of death clearly and fully.

G75574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. G75574

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELIZABETH BOLLINGER

2. DATE OF DEATH June 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3520 Hiltom Road
Hilton Nursing Home

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3520 Hilton Road 15-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Single	May 10, 1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Pa.	

13. FATHER'S NAME: Harry Bollinger

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Katherine Noakes	616 N. Pulaski St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) cerebral hemorrhage
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 10, 1949, to June 21, 1949, *that I last saw the deceased alive on* June 13, 1949 *and that death occurred at* 3 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. H. Buttermuss M. D.	2324 Reisterstown Rd	6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/23/49	St. Peters	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Mrs. Jos. Williams, M.D.	William Cook, Inc.,	1217 St. Paul St.

VS 150

Correct age is especially important. Physician . . . please write

832

G75575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75575

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Carrie Warner Kuehn

2. DATE OF DEATH 6/20/49 5½ a.m.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5407 Hamlet Ave

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 5407 Hamlet Ave 27-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Female	White	Widowed	5/15/1878	71	1	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	At Home	Md.	

13. FATHER'S NAME George A. Warner

14. MOTHER'S MAIDEN NAME Sarah Hamilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mrs Chas. Logan	504 E. 28th St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

DUE TO Hypertensive Cardio-Vascular Renal Disease — 3 yrs.

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 13, 1947, *to* June 21, 1949, *that I last saw the deceased alive on* June 21, 1949, *and that death occurred at* 5:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lloyd E. Saylor M. D.	3902 Greenmount Ave.	June 22 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/23/49	Green Mount	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 150

131a

CERTIFICATE CORRECTED 6-28-49

G75576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75576 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John F Schissler — 5 40.0

2. DATE OF DEATH June 22 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

b. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-10
d. STREET ADDRESS (If rural, give location) 402 Ridgewood Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W	married	May 29 1875	74		

10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Manager
10b. KIND OF BUSINESS OR INDUSTRY American Home Products
11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John H. Schussler
14. MOTHER'S MAIDEN NAME Selina Kuttall
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 225-10-3863A
17. INFORMANT Mrs. D. Seldon Connor Wisconsin ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Duodenal Fistula following
DUE TO (B) Subtotal Gastrectomy for a Peptic Ulcer - Large in posterior stomach wall
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
① Hypochromic Anemia ② Electrolyte imbalance
② Anemia

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION March 49
19B. MAJOR FINDINGS OF OPERATION Peptic ulcer (see above)
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) None
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ None
21F. HOW DID INJURY OCCUR? None

22. *I hereby certify that I attended the deceased from* 6-1-49, 19__, *to* 6-22-49 19__, *that I last saw the deceased alive on* 6-22 19 49, *and that death occurred at* 9A m., *from the causes and on the date stated above.*

23A. SIGNATURE William D. Lyons M.D.
23B. ADDRESS University Hosp.
23C. DATE SIGNED 6-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/25/49
24C. NAME OF CEMETERY OR CREMATORY Woodlawn
24D. LOCATION (City, town, or county) (State) Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 23 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wilson & Son ADDRESS 1217 Eutaw St

VS 150

1117a

correct age is especially important. Physician: please write plainly.

G75577 ✓ 9 ✓ G75577

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) EDWARD JACKSON

2. DATE OF DEATH June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1730 Thames St. 2-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	11/6/05	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
AB seaman	Seafarer	Me.	USA

13. FATHER'S NAME Edward Jackson

14. MOTHER'S MAIDEN NAME Ida Jacobs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 2	259-14-2043	Records- US Marine Hospital	Balto, Md.

MEDICAL CERTIFICATION

Correct age if opposite is important. Physician: please write the cause of death clearly and legibly.

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute hepatitis due to infection	Unknown
	DUE TO	
ANTECEDENT CAUSES	(B) (over)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 18, 1949 *to* June 22, 1949, *that I last saw the deceased alive on* June 22, 1949, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M. D.	US Marine Hospital, Balto, Md.	6/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/24/49	ST. STANISLAUS	BALTIMORE MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Huntington Williams, MD	George R. Weber	705 S. Conn.

VS 150

32a

G75578

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

53

Registered No. G75578

1. NAME OF DECEASED (Type or Print) JAMES WILBUR HUEY

2. DATE OF DEATH June 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital
Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore 21 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pa.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Downingtown
D. STREET ADDRESS (If rural, give location) Route 2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	8/14/15	33		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer	Seafarer	Md.	USA

13. FATHER'S NAME Clarence Huey

14. MOTHER'S MAIDEN NAME Eva Wood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	USA- 1934-1939	Unknown	Records- US Marine Hospital	Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of cecum with generalized metastases — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 2, 1949 *to* June 23, 1949, *that I last saw the deceased alive on* June 23, 1949, *and that death occurred at* 4:40A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M. D.	US Marine Hospital, Balto, Md.	6/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 27/49	Phila. Memorial Park	Chester Co. Penna.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Courtenay for Williams, M.D.	Stewart & Mowen Co.,	1082 W. North Ave.

VS 150

46E

Correct age is especially important. Payment: please write this number on check or draft.

G75579

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75579

Registered No.

1. NAME OF DECEASED (Type or Print): MARY LEVIN

2. DATE OF DEATH: 6-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 916 Whitelock St

C. Length of stay in Baltimore: 70 Yrs. ~~Mos.~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-1
D. STREET ADDRESS (If rural, give location): 916 Whitelock St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 84 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Lowe
14. MOTHER'S MAIDEN NAME: Baila
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: M B Levin ADDRESS: 1111 St Paul St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Senility~~ Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Senility
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 20, 1949 *to* June 22, 1949 *that I last saw the deceased alive on* June 22, 1949, *and that death occurred at* 10:22 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: M B Levin M. D.
23B. ADDRESS: 1111 St. Paul St
23C. DATE SIGNED: June 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-23-49
24C. NAME OF CEMETERY OR CREMATORY: United Hebrew
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw St

VS 150

83B

correct age is especially important. Physicians: please write the

G75580 CERTIFICATE CORRECTED 6-23-49 ✓ G75580

ES-127222 Green Wesley King

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Green King

2. DATE OF DEATH 6-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto City Hospitals

C. Length of stay in Baltimore 6 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1610 W. North Avenue 15-4

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 3, 1921
9. AGE (In years last birthday) 28
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) S.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Quedills
14. MOTHER'S MAIDEN NAME Lillian Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculous Meningitis

DUE TO

(B) Miliary Tuberculosis of the Lung

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ Yes ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-1, 1949, to 6-22, 1949, that I last saw the deceased alive on 6-22, 19 49, and that death occurred at 1110 A., from the causes and on the date stated above.

23A. SIGNATURE R. S. Kozen M. D.
23B. ADDRESS 4940 Eastern Avenue
23C. DATE SIGNED 6-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal
24B. DATE June 23/49
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State) Lexington S.C.

DATE RECEIVED BY LOCAL REGISTRAR JUN 23 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR McCutta Elbert Dgt ADDRESS 1129 N. Carlton St. 12B

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75581

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 410

Registered No. G75581

1. NAME OF DECEASED (Type or Print) LEILA G. WHITE

2. DATE OF DEATH June 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3620 W. Belvedere Ave.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3620 W. Belvedere Ave. 27-18

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	widowed	June 11, 1888	61 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-		Baltimore, Md.	

13. FATHER'S NAME: James Collette

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
-		-

17. INFORMANT: Mrs. Doris Baldwin — ADDRESS: 3620 W. Belvedere

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Cerebral Hemorrhage	7 hours
DUE TO (B)	Rheumatic Heart Disease with Mitral Stenosis and	About 55 yrs.
DUE TO (C)	Aortic Insufficiency	

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 18, 1949, *to* June 21, 1949 *that I last saw the deceased alive on* June 21, 1949, *and that death occurred at* 11 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Julius C. Bluck M. D.	5356 Reisterstown Rd	6/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/24/49	Woodlawn Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

920

G75582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1

G75582

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Harry Granville Moore, Sr.,

2. DATE OF DEATH: June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3236 E. Lombard St.,
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3236 E. Lombard St., 26-10

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Sept. 21, 1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plumber -self	Plumbing,	Baltimore, Md.	

13. FATHER'S NAME: John Granville Moore

14. MOTHER'S MAIDEN NAME: Laura V. Bessee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Harry G. Moore, Jr.	4657 Harcourt Road

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Thrombosis	4 days
ANTECEDENT CAUSES	DUE TO (B) arteriosclerotic cardiovascular disease	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	bronchial asthma	16 yrs ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/19, 1949 *to* 6/22, 1949 *that I last saw the deceased alive on* 6/22, 1949 *and that death occurred at* 4:15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Stanley B. Klyszewicz, M. D.	3500 Erdman Ave	6/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 24, 1949	Parkwood	Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Huntington Williams, M.D.	Ullrich Funeral Home,	2008 Orleans St.,

VS 150

937

correct age is especially important. Physician: please write clearly. Give the cause of death clearly and legibly.

CERTIFICATE CORRECTED 6-30-49

G75583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75583

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Laura Virginia Mooney

2. DATE OF DEATH June 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2824 Elliott Street 1-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	May 5, 1877 1880	72 69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hwfe.		Baltimore, Maryland	

13. FATHER'S NAME Thomas McDonald

14. MOTHER'S MAIDEN NAME Emma Lillian

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Bernard Mooney	2824 Elliott St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pulmonary edema

DUE TO

(B) Arterio-sclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus and Acute Cholecystitis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/18/ , 1949 *to* 6/21/ , 1949 *that I last saw the deceased alive on* 6/21/ , 1949 *and that death occurred at* 7:40 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul E. Parsons Jr. M. D.	1400 N. Caroline St.	6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/24/49	Oak Lawn Cemetery	Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Thurlington Williams, M.D.	Lilly & Zeiler, Inc.	403 S. Wolfe St. (31)

Vs 150

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G75584

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75584

1. NAME OF DECEASED (Type or Print): HORNACK, ANDREW

2. DATE OF DEATH: 6-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital
c. Length of stay in Baltimore: 75 Yrs. More Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore #22
D. STREET ADDRESS (If rural, give location): 6704 Bessemer Ave. 26-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Widowed	March 4, 1873	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Austria	USA

13. FATHER'S NAME: Paul Hornock

14. MOTHER'S MAIDEN NAME: Magdalene Michel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			K. Kline	C.H.&H.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.

DUE TO

(B) Generalized arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic heart disease.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-13, 1949 *to* 6-21, 1949 *that I last saw the deceased alive on* 6-21, 1949 *and that death occurred at* 11⁰⁷ a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nicholas J. Kohlmann, M. D.	Church Home & Hospital	21 June 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/25/49	Holy Redeemer Cemetery	Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Huntington Williams, M.D.	Lilly & Zeiler, Inc.	403 S. Wolfe St. (31)

VS 150

93D

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75585

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75585

1. NAME OF DECEASED (Type or Print): Piggy Steatos

2. DATE OF DEATH: 6-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Sydenham Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sydenham Hospital

c. Length of stay in Baltimore: Since Birth. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 1-5
D. STREET ADDRESS (If rural, give location): 436 S. Patterson Park Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	Single.	7/6/1935	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School	—	U.S. Maryland	USA

13. FATHER'S NAME: Harry Steatos

14. MOTHER'S MAIDEN NAME: Catherine Katsaderas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		—

17. INFORMANT: C. E. Hopkins M.D. — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bilateral Pneumonia
DUE TO
(B) Bacterial Endocarditis
DUE TO
(C) Acute Rheumatic Fever.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1949 *to* June, 1949 *that I last saw the deceased alive on* 6-21-49 19__, *and that death occurred at* 6:30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. E. Hopkins M. D. M. D.	Sydenham Hospital	6-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	6/24/49	Greek Orthodox Evangelisms	Baltimore	aryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Huntington Williams, M.D.	Lilly & Zeiler, Inc.	403 S. Wolfe St. (31)

VS 150

108

Write the cause of death clearly and legibly. Physicians please co-operate by especially

G75586

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

G75586

Registered No.

1. NAME OF DECEASED (Type or Print): SAMUEL EDWARDS

2. DATE OF DEATH: 6/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2786 Tivoly Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2786 Tivoly Avenue 9-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	S	2/6/1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William H. Edwards

14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Family - Same
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 1 year

DUE TO

(B) Hypertension — 1 yr

DUE TO

(C) arteriosclerosis — 1 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Left Hemiplegia — 1 yr

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* June, 19 49 *to* June 21, 19 49 *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 5:30 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE: Isaac Miller M.D. M. D.

23B. ADDRESS: 1221 O'Donnell ST

23C. DATE SIGNED: 6/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): B

24B. DATE: 6/23/49

24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill

24D. LOCATION (City, town, or county) (State): Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 23 1949

REGISTRAR'S SIGNATURE: Certificate for Williams, M.D.

26. FUNERAL DIRECTOR: Jesse L. McCurdy

ADDRESS: 130 E. Fort Ave.

VS 150

83a

G75587 Lillie M. Hickenbottom G75587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 587

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lillie M. Hickenbottom

2. DATE OF DEATH June 19 1949 11:42 P.M.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 940 W. Mulberry St
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-1
D. STREET ADDRESS (If rural, give location) 940 W. Mulberry St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Fem	Col	Widow	June 4, 1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Mayberry, Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Morse
14. MOTHER'S MAIDEN NAME Hannah Brown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Gene Burke Elliott ADDRESS 940 W. Mulberry St

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Tumor of Colon	3 mos. 11 Days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Bowel Obstruction	10 Days
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

230 X

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 8, 1949 *to* June 19, 1949, *that I last saw the deceased alive on* June 19, 1949, *and that death occurred at* 11:42 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Matt Woolridge M. D.
23B. ADDRESS Elkridge Md
23C. DATE SIGNED 6/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/23/1949
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 23 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mrs. Katie R. Williams ADDRESS 322 N. Schroeder St

703 W. Lafay -17 57E

VS 150

Correct age is especially important. Physician please write plainly.

G75588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E. 90 v. 0

G75588 Registered No.

BIRTH NO.

N-805.0

1. NAME OF DECEASED (Type or Print) CHARLES SARAH

2. DATE OF DEATH June 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore 57 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 4-2
D. STREET ADDRESS (If rural, give location) 726 West Lexington Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
male	white	?	?	57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
?	?	Maryland	Yes

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	?	Anna Kelley	724 W Lexington St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushed Chest

DUE TO

(B) Fracture Cervical Vertebrae -

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	726 W. Lexington St. 4/2

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21F. HOW DID INJURY OCCUR?
June 17, 1949 m.		Slipped and fell from room while fixing skylight

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
M.D.		June 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	June 23-49	Holy Cross Cem	Anundel County Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 23 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Joseph Kaminskas Jr. ADDRESS: 602 Washington

VS 151

186a Vital

G75589

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

G75589

Registered No.

1. NAME OF DECEASED (Type or Print) Lucille Short

2. DATE OF DEATH June 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hosp.

C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-2
D. STREET ADDRESS (If rural, give location) 1507 Madison Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow	July 21, 1899	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Surry, Va	U. S. A.

13. FATHER'S NAME Berry Wilkins

14. MOTHER'S MAIDEN NAME Matilda ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mr. Horace Short — ADDRESS 1507 Madison Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Failure

DUE TO

(B) Hypertension

DUE TO

(C) Cerebral Vascular Accident

ANTECEDENT CAUSES

I. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4-20 1949 *to* 6-21 1949, *that I last saw the deceased alive on* 6-21 1949 *and that death occurred at* 6:25 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. Sulaire, M. D.	823 N. Fremont	6-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/24/1949	Family Lot	Surry, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Emerson Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave.

VS 150

131a

G75590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75590

BIRTH NO. G75590

1. NAME OF DECEASED (Type or Print) Oliver Joyner

2. DATE OF DEATH 6/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1428 Riggs Ave.
C. Length of stay in Baltimore 27 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1428 Riggs Ave. 16-2

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Aug. 13, 1922
9. AGE (In years last birthday) 26
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk P.O.
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto. Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Charles Joyner - Balto, Md
14. MOTHER'S MAIDEN NAME Frances Barnett - Balto Md
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Frances Joyner ADDRESS 1428 Riggs

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L Royster M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 6/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/23/49
24C. NAME OF CEMETERY OR CREMATORY Arbutus Cem
24D. LOCATION (City, town, or county) (State) Balto. Co
DATE RECEIVED BY LOCAL REGISTRAR JUN 23 1949
REGISTRAR'S SIGNATURE Investigator for Williams, M.D.
25. FUNERAL DIRECTOR Holland Funeral Home ADDRESS 1631 D. H. Ave

13B

VS-151

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

075591

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 075591

1. NAME OF DECEASED (Type or Print): Minnie Garnett Marshall

2. DATE OF DEATH: June 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2012 Division Street

c. Length of stay in Baltimore: 50 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2012 Division Street 14-3

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 10, 1884
9. AGE (In years last birthday): 65 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Essex Co, Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mr George S. Marshall
ADDRESS: 2012 Division

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Arthritus — 5 yrs
DUE TO
(B) Cardio Vascular Disease — 3 yrs
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 16, 1949 to June 20, 1949 that I last saw the deceased alive on June 1, 1949 and that death occurred at 4 A. m., from the causes and on the date stated above.

23A. SIGNATURE: E William Frey M. D.
23B. ADDRESS: 1928 Penna Ave
23C. DATE SIGNED: 6/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/23/49
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Pk
24D. LOCATION (City, town, or county) (State): Baltimore Co, Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 D.H. Ave

VS 150

93C

G75592

CERTIFICATE CORRECTED 5-22-50 ✓

No. 1

G75592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Robert Edgworth Jenkins

2. DATE OF DEATH: June 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1717 Druid Hill Ave

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 14-2
D. STREET ADDRESS (If rural, give location): 1717 Druid Hill Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Married	April 26 1913	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Baltimore, Md.	U. S. Co.

13. FATHER'S NAME: William Wyand

14. MOTHER'S MAIDEN NAME: Idoline Jenkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. [illegible] Jenkins ADDRESS 1717 Druid Hill Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 days

DUE TO

(B) Hypertensive cardiac disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Overweight

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify). | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 19__, *to* June 19, 19 49 *that I last saw the deceased alive on* 6-19, 1949, *and that death occurred at* 11:22 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo H Pendleton M. D.	1723 Druid Hill Ave	6-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/24/49	Mt. Auburn Cem.	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Huntington	Williams, Md. Holland Funeral Home	1691 Druid Hill Ave 931

VS 150

G75593
ES-127223

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75593
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Letha Williams (Lethia Williams)

2. DATE OF DEATH 6-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Balto. City Hospitals

c. Length of stay in Baltimore 40 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1408 Pennsylvania Ave. 14-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Married	June 16, 1898	51	0 / 5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gaines, James
14. MOTHER'S MAIDEN NAME Emma Banks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT RECORDS BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write clearly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular Accident
DUE TO

ANTECEDENT CAUSES
(B)
DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C) Arteriosclerotic Heart Disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-1 1949, *to* 6-21 1949, *that I last saw the deceased alive on* 6-21 1949, *and that death occurred at* 10:15 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE R. S. Rogers M. D.
23B. ADDRESS 4940 Eastern Avenue
23C. DATE SIGNED 6-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6-25-49
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn
24D. LOCATION (City, town, or county) (State) Baltimore 17, Md.,

DATE RECEIVED BY LOCAL REGISTRAR JUN 23 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR ADDRESS Wm. A. Jackson, 916 Penna. Ave.,

937

VS 150

CERTIFICATE CORRECTED 6-22-49 ✓

G75594

G75594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 ✓

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Stichel

2. DATE OF DEATH June 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

C. Length of stay in Baltimore 71 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-3

D. STREET ADDRESS (If rural, give location) 411 North Chester St #31

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 7/23/1878

9. AGE (In years last birthday) 70 | If Under 1 Year: Months 9 Days 28 | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?

10B. KIND OF BUSINESS OR INDUSTRY Easton Rolling Mills

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME William Stichel

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-01-1827

17. INFORMANT Lawrence Stichel ADDRESS 411 N. Chester St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation and

DUE TO uremia and cerebral hemorrhages

(B)

DUE TO

(C) Hypertensive arteriosclerotic cardiovascular renal disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Benign prostatic hypertrophy

INTERVAL BETWEEN ONSET AND DEATH

6-8 mos decompensated
1st hemorrh 2 yrs ago
2nd hemorrhage 3 wks ago

16-1342

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-6, 1949 *to* 6-22, 1949 *that I last saw the deceased alive on* 6-22, 1949 *and that death occurred at* 9:35 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE Marguerite Louise Candler M. D.

23B. ADDRESS Maryland General Hospital

23C. DATE SIGNED 6/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6/26/49

24C. NAME OF CEMETERY OR CREMATORY Oak Lawn

24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR JUN 23 1949

REGISTRAR'S SIGNATURE Thurlington for Matthews, M.D.

25. FUNERAL DIRECTOR Philip Herwig Sons

ADDRESS 2024 Orleans St - 31

VS 150

1310

Correct age is especially important. Physician please write the cause of death clearly and legibly.

G75595

Trintress

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75595

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Daisy Trintress BOYD

2. DATE OF DEATH June 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore 5 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 444 W. Conway St. 22-2

5. SEX female | 6. COLOR OR RACE colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 4/27/1922 | 9. AGE (In years last birthday) 27 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY Rubber Factory

11. BIRTHPLACE (State or foreign country) Manning S.C

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Ecdudor Hatvey

14. MOTHER'S MAIDEN NAME Laura Pearson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Laura Pearson, Manning, S.C. ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	Chronic alcoholism	
(A)		
DUE TO		
(B)		
DUE TO		
(C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from* (Autopsy, Inspection or Inquiry) *the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 12 Jun 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6/23/49

24C. NAME OF CEMETERY OR CREMATORY Mt Auburn

24D. LOCATION (City, town, or county) (State) Baltimore, City

25. FUNERAL DIRECTOR Isaiah L. Brown ADDRESS 1417 W Montgomery St

DATE RECEIVED BY LOCAL REGISTRAR JUN 23 1949

REGISTRAR'S SIGNATURE Trintreston Williams, M.D.

VS 151

777

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Important: please write the cause of death clearly and legibly.

TIFICATE CORRECTED 8-3-49 ✓

G75596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

592 Registered No. G75596

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (37[illegible]) Clerisia Dingle

2. DATE OF DEATH June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 712 S. Sharp St. 22-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	M	4/9/~~1901~~ 1912	4937				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Manning S. C	

13. FATHER'S NAME: West Ballard

14. MOTHER'S MAIDEN NAME: Elinah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT: Janie Leak ADDRESS: 935 Leadenhall St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Glomerulo Nephritis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Rogers M.D.		June 22 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/25/49	Mt Auburn	Balto City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Huntington Williams, M.D.	J. J. Brown & Son	1608 W Montgomery St

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 151

131B

G75597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 31

G75597

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Esther J. Hill

2. DATE OF DEATH 6/22/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 803 Vine St.

C. Length of stay in Baltimore 24 Yrs. [ ] Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 803 Vine St 18-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col	Widow	Feb-7-1893	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic Work		Blackstone - Va	U.S.

13. FATHER'S NAME David Fowler

14. MOTHER'S MAIDEN NAME Mary Austin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Hattie Pryor	1111 McKean Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Hypertension Nephritis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 2 hrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [ ] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/10, 1949 *to* 6/22, 1949 *that I last saw the deceased alive on* 6/21, 1949, *and that death occurred at* 8 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Frankel M. D.	1212 W Fayette	6/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	6/28/49	Mt. Calvary	Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Huntington Williams, M.D.	A. Halitegod	918 Druid Hill Ave.

VS 150

1312

G75598

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H 3

Registered No. G75598

1. NAME OF DECEASED (Type or Print) Dr. FRANK LEVINSON

2. DATE OF DEATH 6/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 15-10

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSP

c. Length of stay in Baltimore Yrs. 40 Mos. Yrs Days

D. STREET ADDRESS (If rural, give location) 4004 LIBERTY HEIGHTS AVE.

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH Apr 25 1890

9. AGE (In years last birthday) 59

If Under 1 Year: Months, Days

If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY PHYSICIAN

11. BIRTHPLACE (State or foreign country) NEW YORK

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ABRAHAM LEVINSON

14. MOTHER'S MAIDEN NAME Jennie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes World War #1

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Mrs. Hortense H. Levinson 4004 Lib.Hgts.Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HEMORRHAGE FROM ARTERY IF BRAIN DUE TO ARTERIOSCLEROSIS

DUE TO (B) CHEMIPLEGIA - RT.

DUE TO (C) HYPERTENSIVE CVD - ENLARGED HEART

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/12, 19 49 *to* 6/23, 19 49, *that I last saw the deceased alive on* 6/22, 19 49 *and that death occurred at* 1:55 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Donald W. Montz M. D.

23B. ADDRESS Church Home Hosp.

23C. DATE SIGNED 6/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6/24/49

24C. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew Cem.

24D. LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 23 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR WM. J. TICKNER & SONS

ADDRESS Balto., Md.

VS 150

93D

G75599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176

G75599

BIRTH NO. B.C. 49-12500 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Strickland

2. DATE OF DEATH: 6-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: 10 Hours

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-3
D. STREET ADDRESS (If rural, give location): 2334 Madison Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro		6-21-49			10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland, Baltimore	

13. FATHER'S NAME: Edwin Strickland

14. MOTHER'S MAIDEN NAME: Margaret Estelle Ranf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mother — ADDRESS: 2334 Madison Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Immaturity (weak) - 2 wks

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-21- *,* 19 49 *, to* 6-22- *,* 19 49 *, that I last saw the deceased alive on* Jun 22 *,* 19 49 *, and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. Hodgson Heyser M. D.	22-43 Madison	6-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
	6-23-49	Arlington	Balto Co	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Huntington Williams, M.D.	Samuel W. Sullivan Jr.	Balto.

VS 150

159

Correct age is especially important. Physician: please write the

GM. 125563

G75600

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75600

1. NAME OF DECEASED (Type or Print): Lida Drobisch

2. DATE OF DEATH: June 22 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS. (If rural, give location): 2500 Hamilton Ave. 2-7-06

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Wid.
8. DATE OF BIRTH: Jan. 2- 1888
9. AGE (In years last birthday): 61
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William M. Longville
14. MOTHER'S MAIDEN NAME: Margaret J. Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.

17. INFORMANT: B.C.H. Records 4940 Eastern Ave. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Far Advanced Pulmonary Tuberculosis — Interval between onset and death: 7 Months
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes Mellitus — 6 Yrs.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12- 25- , 1948 to 6- 22- , 1949 *that I last saw the deceased alive on* June 22, 1949 *and that death occurred at* 12.30 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 6-22-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-24-49
24C. NAME OF CEMETERY OR CREMATORY: Western
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard Luck
ADDRESS: 5305 Harford

VS 150

13B

G75601

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

20-1

G75601

Registered No.

1. NAME OF DECEASED (Type or Print): Stuart H. Brown

2. DATE OF DEATH: June-23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1605 Park Avenue

C. Length of stay in Baltimore: 7 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 1605 Park Avenue 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widower	11-13-1865	83		16		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Insurance	St. Louis - Mo.	U.S.A.

13. FATHER'S NAME: Henry Stuart Brown

14. MOTHER'S MAIDEN NAME: Emma Jane Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (Sister)	ADDRESS
No	No	218-22-7740A	Mrs. Edith B. Bousseau	1605 Park Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — 29 days

DUE TO

(B) arteriosclerosis — years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
N		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from March, 1942, to June 23, 1949, that I last saw the deceased alive on June 21, 1949, and that death occurred at 2:30A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frances W. Gluck M. D.	3406 St Paul St	6/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	June-23-1949	Loudon Park Cem	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 23 1949	Huntington Williams, M.D.	Stewart & Mowen Co.,	108 W. North Ave. 94a Balto. #1, Md.

VS 150

BIRTH NO. G75602

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 9 76.0 G75602 Registered No.

1. NAME OF DECEASED (Type or Print): Steven Grabowski N-861-4

2. DATE OF DEATH: June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): 330 Rosebank Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	W	Divorced	?	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur		Baltimore	

13. FATHER'S NAME: John Grabowski

14. MOTHER'S MAIDEN NAME: Mary Archik

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
	No	

17. INFORMANT: Mary Ceska ADDRESS: 2240 W. Balto. St.

MEDICAL CERTIFICATION

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bullet wound of brain
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): 2240 W. Balto. St.
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Sister's Home, 2240 W. Balto. St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 22, 1949 ?
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Firearms

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].

23A. SIGNATURE: Earl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: June 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 24/49	Holy Rosary	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUN 23 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
FUNERAL DIRECTOR: Fred W. Ozarowski
ADDRESS: 164 E. 930 Edgewood Ave

G75603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75603

BIRTH NO. B.C. 49-12484

1. NAME OF DECEASED (Type or Print) Baby Girl Gamble Twin A

2. DATE OF DEATH 6-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 631 N. Calvert St. Balto #2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Single	6-21-49			1	17	20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Harry Gamble

14. MOTHER'S MAIDEN NAME Frances Gamble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT above ADDRESS 631 N. Calvert St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial Hemorrhage

DUE TO

(B) Ct

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ct Measures

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-21, 1949, *to* 6-22, 1949, *that I last saw the deceased alive on* 6-22, 1949, *and that death occurred at* 10:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE L. M. Snulson M. D.

23B. ADDRESS Mercy Hosp

23C. DATE SIGNED 6-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6-24-49

24C. NAME OF CEMETERY OR CREMATORY Cathedral

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR JUN 24 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Heidelfelt & Sons

ADDRESS Belmont & 22nd 160a

VS 150

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

7-54-4

G75604 Registered No.

BIRTH NO. B.C. 49-10603

1. NAME OF DECEASED (Type or Print): Betty Sue Vaughn

2. DATE OF DEATH: June 23, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1612 Eutaw Place 14-07

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	5/9/49		1 / 14	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James D. Vaughn

14. MOTHER'S MAIDEN NAME: Lucile E. Watts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Jas. D. Vaughn ADDRESS: 1612 Eutaw Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Aspiration of vomitus.
DUE TO atelectasis of lungs.
DUE TO Congenital heart, lungs.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: June 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/24/49	Prospect Hill	Towson Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 24 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm Cook Inc ADDRESS: 217 St. Paul St.

VS 151

157E

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Dr. Wilcock 1227 Washington Blvd

75605 BALTIMORE CITY HEALTH DEPARTMENT 43 G75605

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): EMMA JANE FOX

2. DATE OF DEATH: 6/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 7. S. ARLINGTON AVE

c. Length of stay in Baltimore: 1 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 15
D. STREET ADDRESS (If rural, give location): 7. S. ARLINGTON AVE

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: OCT 25, 1861
9. AGE (In years last birthday): 87 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DUNCAN
14. MOTHER'S MAIDEN NAME: UNKNOWN SWOUP

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ELSIE SHAFER ADDRESS: 7. SOUTH ARLINGTON AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia bilateral — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

(B) Hypertensive Cardio-Vascular Disease, arteriosclerosis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 16 1949 *to* June 24 1949, *that I last saw the deceased alive on* June 23 1949, *and that death occurred at* 2:45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: John P. Wilcock, Jr. M. D.
23B. ADDRESS: 1227 Wash. Blvd
23C. DATE SIGNED: 6-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 6/26/49
24C. NAME OF CEMETERY OR CREMATORY: FOXVILLE
24D. LOCATION (City, town, or county) (State): FOXVILLE MARYLAND

DATE RECEIVED BY LOCAL REGISTRAR: JUN 24 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: M. L. Creaga & Sons ADDRESS: Thurmont, Md.

VS 150

93D

G75606 BIRTH NO. B.C. 49-11188

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 796

G75606 Registered No.

1. NAME OF DECEASED (Type or Print): BABY BOY BRUNSON

2. DATE OF DEATH: 5-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: 5 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 12-07
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17
D. STREET ADDRESS (If rural, give location): 2501- N. Howard St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	Infant	5-26-49			5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frank Brunson
14. MOTHER'S MAIDEN NAME: Ashley Brunson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory Failure
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-26-, 1949, *to* 5-31-, 1949, *that I last saw the deceased alive on* 5-31-, 1949, *and that death occurred at* 10:2A m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. A. Hamman M.D. — 23B. ADDRESS: Univ. Hosp. — 23C. DATE SIGNED: 6-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify) — 24B. DATE — 24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL — 24D. LOCATION (City, town, or county) (State): JUN 6 1949

DATE RECEIVED BY LOCAL REGISTRAR: JUN 24 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: [redacted] — ADDRESS

VS 150

City Disposal

159

G75607

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75607

Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM JONES

2. DATE OF DEATH: June 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1104½ Stricker

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1104 N. Stricker St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1104 N. Stricker St. 16-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (in years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Married	Feb. 18, 1892	57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Minister		North Carolina	U. S. A.

13. FATHER'S NAME: James Jones

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Margaret Jones ADDRESS: 1104 N. Stricker St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 2 Wks

DUE TO

(B) Myocarditis

DUE TO

(C) Chron. Gastritis, Anemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 14, 1949 *to* June 20, 1949 *that I last saw the deceased alive on* June 20, 1949, *and that death occurred at* 7P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. R. Berry M.D.	1133 E. Monroe	6-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-24-49	Arbutus Mem. Park	Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 24 1949	Huntington Williams, M.D.	Mrs. Frances A. Hemsley	578 W. Biddle St

VS 150

93E

G75608
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 G75608
Registered No.

1. NAME OF DECEASED (Type or Print): Lydia Bergen

2. DATE OF DEATH: 6-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 8 - 7
D. STREET ADDRESS (If rural, give location): 702 E HOFFMAN ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	WIDOWED	9-86	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H. WIFE	H. WIFE	BALTIMORE	U.S.A.

13. FATHER'S NAME: WILLIAM J. LEACH

14. MOTHER'S MAIDEN NAME: ELLA L. ENGLAND

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
None	none	none	DAUGHTER	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular Disease — Interval between onset and death: Unknown
DUE TO
(B) Arteriosclerosis Generalized — Interval between onset and death: Unknown
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Robert B McFadden M.D.		6-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/27/49	Baltimore Cemetery	E North Ave. Balto MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 24 1949	Huntington Williams, M.D.	Howard N. Bligh Jr.	600 Harford Rd Balto 14. Md

VS 151

93-1

Correct age is especially important. Physician: please write the

75609

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 903.0 ✓

G75609

Registered No.

1. NAME OF DECEASED (Type or Print) Shure Grace Sanders — N-820.0

2. DATE OF DEATH June 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland University Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

C. Length of stay in Baltimore — Yrs. Life, Mos., Days 12-03

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY Balto. City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 2413 N. Calvert Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Aug-29-1874	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teaching	Retired School Prin.	Baltimore, Md	U. S. A.

13. FATHER'S NAME Matthais Sanders

14. MOTHER'S MAIDEN NAME Margaret Sumwalt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	—	None

17. INFORMANT — ADDRESS
Mrs. Mildred C. Englehardt — 616 Parkwyorth

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH
DUE TO Fracture of Neck of femur
(B) Hypertension, Arteriosclerotic C-V
DUE TO Disease
(C) Coronary Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
Earl L Roy M.D.
CHIEF OF ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June 7, 1949	Fracture Neck of femur	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Home	2314 N. Calvert St. 12/3.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
June 6, 1949 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Slipped on throw Rug To Floor

22. I hereby certify that I attended the deceased from June 2, 1949 to June 23, 1949 that I last saw the deceased alive on June 22, 1949 and that death occurred at 8 A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Deitzler M. D.	University Hospital	6-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June-25-1949	London Park	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 24 1949 VS 150	Lexington Williams, M.D.	Stewart & Mowen Co.,	108 W. North Ave 186a Balto. #1, Md.

Correct age is especially important. If unknown, please write "unknown."

G75610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1 G75610

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ARTHUR L. BILLHIMER

2. DATE OF DEATH June 22 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1535 Ensor St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) -

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1535 Ensor St. 9-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	married	July 8 1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Vet man	Gas + Electric Co	Virginia	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles E. Billhimer	Susie Anna Bateman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Helen V. Billhimer	1535 Ensor St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Interval between onset and death: Sudden

DUE TO

(B) Arteriosclerotic CVD

DUE TO

(C) Myocarditis - Angina Pectoris — 4 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 12, 1949 *to* June 22, 1949 *that I last saw the deceased alive on* June 22, 1949, *and that death occurred at* 11:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Laurence J. Schmaush M. D.	3211 Hall Rd.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	June 25/49	Bodlawn	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 24 1949	Huntington Williams, M.D.	Fenton E. Donovan	3638 Roland Ave

VS 150

93D

G75611

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75611

BIRTH NO. B.C. 49-11528

1. NAME OF DECEASED (Type or Print) David Craig Fauble

2. DATE OF DEATH 6-23-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Bon Secours Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital

c. Length of stay in Baltimore ~~Yrs~~ ~~Mos.~~ 16 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-07

D. STREET ADDRESS (If rural, give location) 153 Edgewood St

5. SEX	6. COLOR OR RACE	7. SINGLE, ~~MARRIED, WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W		6-7-49	16 days		16	11	hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
X	X	BALTIMORE	

13. FATHER'S NAME Clarence Harrison Fauble

14. MOTHER'S MAIDEN NAME Lucia Bonita Zuccarini

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

Cause age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PUL ATELECTASIS

DUE TO

(B) Pneumonitis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: !

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-7 19 49 *to* 6-23 19 49 *that I last saw the deceased alive on* 6-23 19 49, *and that death occurred at* 10 30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	Bon Secours Hosp	6-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/24/49	Zion	Dorsey Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 24 1949	Huntington Williams, M.D.	Clarence Harrison Fauble. 153 Edgewood St. Baltimore Md

VS 150

159

G75612

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

D G75612
Registered No.

1. NAME OF DECEASED (Type or Print): Howard Nixon

2. DATE OF DEATH: 6/21/49 8:30 P.M

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1355 N. Carey St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1355 N. Carey St. Balto, Md
c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 15-41
D. STREET ADDRESS (If rural, give location): 1355 N. Carey St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	W	8/?/1882	66 64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Md.	

13. FATHER'S NAME: ??

14. MOTHER'S MAIDEN NAME: ??

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		??

17. INFORMANT: Fred Wilson ADDRESS: 1355 N. Carey St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arterio-sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: unk.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5/19 1949 *to* 6/21 1949 *that I last saw the deceased alive on* 6/21 1949 *and that death occurred at* 3:45 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	RAYNER BROWNE, M.D. 1500 EAST MADISON ST. BALTIMORE 5, MD.	6-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City or county) (State)
Burial	6/24/49	Arbutus Memorial Pk, Inc.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 24 1949	Huntington Williams, M.D.	Geo. G. Kelson	1303 Presstman St,

VS 150

93D

5613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75613 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Smith

2. DATE OF DEATH June 24. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cold Spring Nursing Home

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 7000 Lettia Ave 25-32

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH 3/12/1886
9. AGE (In years last birthday) 81
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob LuLay
14. MOTHER'S MAIDEN NAME Matilda Zang

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Frank J. Smith ADDRESS 7000 Lettia Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CHRONIC MYOCARDITIS — INTERVAL BETWEEN ONSET AND DEATH: 2 yr—

DUE TO

(B) ARTERIOSCLEROSIS GENERAL — 10 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* May 15, 1948, *to* June 23, 1949, *that I last saw the deceased alive on* 6/23, 1949, *and that death occurred at* 3 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE Herman R. Kleiman, M. D.
23B. ADDRESS 3803 Edmondson Ave
23C. DATE SIGNED 6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/29/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 24 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Edward Fenlon ADDRESS 2359 W. Fosh Blvd

VS 150

937

G75614

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59 Registered No. G75614

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Richard Brown

2. DATE OF DEATH June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2102 N. Howard St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore 23 Yrs. Mos. Days

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Oct. 10. 1897
9. AGE (In years last birthday) 51
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor
10B. KIND OF BUSINESS OR INDUSTRY Garage
11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jim Brown
14. MOTHER'S MAIDEN NAME Sine Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-09-7426
17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Uremia	Weeks.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) chronic glomerulo nephritis	years.
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* 6-22, 1949 *to* 6-22, 1949 *that I last saw the deceased alive on* 6-22, 1949, *and that death occurred at* 1045 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Anthony J. Bass M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 6-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/27/49
24C. NAME OF CEMETERY OR CREMATORY Arbutus
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 24 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR William J. Chatsmanp Jr
ADDRESS 1201 Mc Balto. Md.

1316

VS 150

Correct age is especial important. Physician: please write the cause of death clearly and legibly.

G75615 JL - 118342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75615

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Carl Savoy**

2. DATE OF DEATH **June 16, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Baltimore City Hospitals 4940 Eastern Ave.**

c. Length of stay in Baltimore **15 yrs.** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **1413 Druid Hill Ave.** 14-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	Negro	Single	Feb. 2, 1893	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		India	

13. FATHER'S NAME **Willian ?**

14. MOTHER'S MAIDEN NAME **Necly Cosetta ?**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		B. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Tuberculous Meningitis** — INTERVAL BETWEEN ONSET AND DEATH: **10 Days**

DUE TO

(B) **Pulmonary Tuberculosis**

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	None	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* **March 22**, 19**48** *to* **June 16**, 19**49**, *that I last saw the deceased alive on* **June 16**, 19**49** *and that death occurred at* **9.35P** *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. S. Rogers M. D.	4940 Eastern Ave.	6-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL JUN 21 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 24 1949	Huntington Williams, M.D.	Huntington Williams, M.D.	1

VS 150

1313

G75616 KRENZ ✓ G75616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Edward L. Krenz

2. DATE OF DEATH 6-22-1949

3. PLACE OF DEATH: Baltimore City, Maryland 1924 N. Milton Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1924 N. Milton Ave 8 0 ✓

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Sept. 3-1891	57 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY Fairfax Brush Co.

11. BIRTHPLACE (State or foreign country) Washington D C

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Albert Krenz

14. MOTHER'S MAIDEN NAME Mary Louise Owens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-01-9114

17. INFORMANT Margaret L. Krenz ADDRESS 1924 N. Milton Ave

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of larynx — INTERVAL BETWEEN ONSET AND DEATH: Sept 1948

DUE TO

ANTECEDENT CAUSES

(B) —

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
5-2-49	Carcinoma of Larynx	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4-9-, 1949 *to* 6-22-, 1949 *that I last saw the deceased alive on* 6-22, 1949 *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Milton C. Carey M. D.	2117 Belair Rd	6-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-25-49	Baltimore Cemetery	North Ave. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 24 1949	Huntington Williams, M.D.	John E. Kelly Inc.	2235 E. Oliver St

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G75617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75617

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lloyd Lowe Lomax

2. DATE OF DEATH: JUN 23 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 0 Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY: Talbot
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wittman
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	?-1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Silas Lomax

14. MOTHER'S MAIDEN NAME: Ida Seymour

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis

DUE TO

(B) Bronchiogenic Carcinoma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 5-19- *, 1949 to* 6-23- *, 1949, that I last saw the deceased alive on* 6-23 *, 1949, and that death occurred at* 11:55 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: John Collins Harvey M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: June 26/49

24C. NAME OF CEMETERY OR CREMATORY: Olivet

24D. LOCATION (City, town, or county) (State): St. Michaels, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 24 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John O. Mitchell Son,

ADDRESS: 1905 Eutaw Place

VS 150

47c.

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75618 BALTIMORE CITY HEALTH DEPARTMENT 331 G75618

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY KILCHENSTEIN

2. DATE OF DEATH 6-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3344 Old York Rd

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 9-03
D. STREET ADDRESS (If rural, give location) 3344 Old York Rd

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH April 2 1874 | 9. AGE (In years last birthday) 75 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William T. Sheehey

14. MOTHER'S MAIDEN NAME Bridget White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Florence Nichol ADDRESS 3344 Old York Rd

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrage. — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. fracture right humerus

CERTIFICATION APPROVED BY
G. G. Merrill M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) acc.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3344 Old York Road 9/3

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct. 18, 1948 m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Fell out of bed

22. *I hereby certify that I attended the deceased from* Jan, 1949, to June, 1949, *that I last saw the deceased alive on* May 20, 1949, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.

23B. ADDRESS 632 Cathedral

23C. DATE SIGNED June 22-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE 6-25-49

24C. NAME OF CEMETERY OR CREMATORY St. Mary's Govan's

24D. LOCATION (City, town or county) (State) BALTIMORE Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 24 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John G. Moran ADDRESS 1008 Balt. St.

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G75619

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

560

G75619

Registered No.

1. NAME OF DECEASED (Type or Print) Augusta Wiechert or Weichert

2. DATE OF DEATH 6-24-49

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 N. Linwood Ave

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
C. CITY OR TOWN BALTIMORE (If outside corporate limits, write RURAL and give township) 6 01
D. STREET ADDRESS (If rural, give location) 31 N. Linwood Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	7-7-1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		GERMANY	

13. FATHER'S NAME ? KINAPPLE

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		FRANK W. WIECHERT	31 N. LINWOOD Ave

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ARTERIOSCLEROSIS — INTERVAL BETWEEN ONSET AND DEATH: 6 YRS
DUE TO
(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) ACUTE CARDIAC FAILURE — 2 DAYS

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 20, 1949 *to* June 27, 1949 *that I last saw the deceased alive on* June 27, 1949, *and that death occurred at* 2A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James J. Cavanaugh M.D. M. D.	3014 Mc Elderry St	6-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-27-49	BALTIMORE	BALTIMORE Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 24 1949	Huntington Williams, M.D.	John G. Moran	3000 E. Balt. St.

VS 150

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G75620 - 129651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

491 Registered No. G75620

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Robert Phoenix

2. DATE OF DEATH June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 8 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 517 Brune St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Negro	?	? ? ?	50 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		?	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
?	?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		B. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute bacterial endocarditis pneumococci
DUE TO
(B) Bronchopneumonia
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cancer of prostate

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES XXX NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 14, 19 49 *to* June 22, 19 49 *that I last saw the deceased alive on* June 22, 19 49 *and that death occurred at* 8 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T. S. Cozen M. D.	4940 Eastern Ave.	6-24-49

24A. BURIAL, CREMATION OR REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-25-49	Mt. Auburn	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 24 1949	Huntington Williams, M.D.	Wm. Katz R. Williams	822 W. Lafayette Ave

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51B

G75621
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75621
Registered No.

1. NAME OF DECEASED (Type or Print): Cora Price

2. DATE OF DEATH: June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy
C. Length of stay in Baltimore: 32 yrs — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2420 N. Howard St. 12-07

5. SEX: F
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 1908
9. AGE (In years last birthday): 41 — If under 1 year: Months, Days — If under 1 day: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Griffin, Ga
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Williams
14. MOTHER'S MAIDEN NAME: Mollie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.
17. INFORMANT: Rev Paul N. Price — ADDRESS 2420 N Howard St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertension C.V. Renal
DUE TO
(B) Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Emil L Kruse M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: June 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-25-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State): Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 24 1949
REGISTRAR'S SIGNATURE: Turnington Williams M.D.
25. FUNERAL DIRECTOR: Wm. Katie R. Williams
ADDRESS: 3929 W Lafayette Ave

VS 151

131a

G75622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 4 3

Registered No. G75622

BIRTH NO. B.C. 49-08960

1. NAME OF DECEASED (Type or Print) JESSIE SMITH

2. DATE OF DEATH 6-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SYDENHAM HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 45. Amity St. Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 18 03
D. STREET ADDRESS (If rural, give location) 4 S. Amity St. Baltimore MD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	COLORED	SINGLE	4-27-48	1 yr 2 mo				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME James

14. MOTHER'S MAIDEN NAME Annie Hollis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. child

17. INFORMANT Father James ADDRESS 4 S. Amity St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I	(A) Encephalitis - Etiology unknown (TBc, Toxoplasmosis?)	11 days
	DUE TO (B)	
	DUE TO (C)	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-13, 1949, *to* 6-23, 1949, *that I last saw the deceased alive on* 6-23, 1949, *and that death occurred at* 10 12 *m., from the causes and on the date stated above.*

23A. SIGNATURE Jerry D Cohen M. D.

23B. ADDRESS Sydenham Hosp.

23C. DATE SIGNED 6-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6-25-49

24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem

24D. LOCATION (City, town, or county) (State) Balto. Md.

25. FUNERAL DIRECTOR ADDRESS Mr. Nate R. Williams 3229 Johnson St.

DATE RECEIVED BY LOCAL REGISTRAR JUN 24 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

VS 150

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G75623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

581.0

Registered No. G75623

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Joyner

2. DATE OF DEATH 6-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1531 Edmondson Ave.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1531 Edmondson Ave 19-01

5. SEX Male

6. COLOR OR RACE Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Nov. 20 1882

9. AGE (In years last birthday) 76 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Wilmington N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Richard

14. MOTHER'S MAIDEN NAME Roena Gardner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mable Joynes ADDRESS 1531 Edmondson ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myelotrophic Leukosis

DUE TO

(B) Arthosis of Spine

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-17-1949 to 6-21-1949, that I last saw the deceased alive on 6-19-1949, and that death occurred at [illegible] p. m. from the causes and on the date stated above.

23A. SIGNATURE Wand Saunders M. D.

23B. ADDRESS 1422 W. Lee

23C. DATE SIGNED 6-24-49

24A. BURIAL, CREMATION OR REMOVAL (Specify) Burial

24B. DATE 6-25-49

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem

24D. LOCATION (City, town, or county) (State) Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 24 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR Mrs Kate R. Williams ADDRESS 822 N Schroeder St

VS 150

124B

G75624

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75624 Registered No.

1. NAME OF DECEASED (Type or Print): Donna Sue Ash

2. DATE OF DEATH: June 9 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Harriet Lane

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY A A
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Annapolis
D. STREET ADDRESS (If rural, give location) Box 132

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 6-15-49
9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.: 4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Roy Ash
14. MOTHER'S MAIDEN NAME: Ruby Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital atresia of oesophagus - operated.
DUE TO
(B) Post-operative pneumo. & Atelectasis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/17, 1949, *to* 6/19, 1949, *that I last saw the deceased alive on* 6/19, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JUN 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

Hospital - Disposal

1579

Please write plainly. Physician's special attention is especially directed to the items marked important. Correct age is especially desired.

G75625 BIRTH NO. B.C. 49-12069

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

130 G75625 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Kennedy

2. DATE OF DEATH: June 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

c. Length of stay in Baltimore: 6 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3051 Southland Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	B		June 13, 1949			1	5	10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Eliza Dozier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Eliza Kennedy ADDRESS: 3051 Southland Avenue

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G75626 X 1 G75626

BIRTH NO. BC 49-07381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 753

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Whittaker

2. DATE OF DEATH: June 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital
C. Length of stay in Baltimore: 2 mo. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middle River
D. STREET ADDRESS (If rural, give location): 28 Decatur Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	April 8, 1949		2	3	2	5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Walton Whittaker
14. MOTHER'S MAIDEN NAME: Virginia Powell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Virginia Powell ADDRESS: 28 Decatur Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Anoxia
DUE TO
(B) Central nervous system disease of unknown etiology.
DUE TO
(C) ? Hydrocephalus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Multiple hemangiomata

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 8, 1949 *to* June 11, 1949 *that I last saw the deceased alive on* June 11 1949, *and that death occurred at* 1:45 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Glen G. Rice M. D.
23B. ADDRESS: 601 North Broadway
23C. DATE SIGNED: June 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Hoff Disford
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JUN 24 1949
REGISTRAR'S SIGNATURE: Curtis Williams, MD
25. FUNERAL DIRECTOR:
ADDRESS:

VS 150

56E

Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

G75627

BIRTH NO. B.C. 49-11081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 751

G75627

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Ashwell

2. DATE OF DEATH: June 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. 0 Mos. 6 days at J.H.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sparrows Point
D. STREET ADDRESS (If rural, give location): 7302 Bay Fort Road

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: May 31, 1949
9. AGE (In years last birthday) | If Under 1 Year: Months | Days: 5 | If Under 24 Hours: Hours: 13 | Min.: 48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Frank Ashwell
14. MOTHER'S MAIDEN NAME: Grace Barton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Grace Ashwell
ADDRESS: 7302 Bay Fort Road

MEDICAL CERTIFICATION

Write the cause of death clearly and legibly. Physician: please write correct age if special. Important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningitis

DUE TO

(B) Multiple congenital anomalies: Encephalocele, Spina bifida, Club feet, Hare-lip, Cleft palate

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 31, 1949 19 *, to* June 6 *, 19* 49 *that I last saw the deceased alive on* June 6 *, 19* 49 *and that death occurred at* 6:20 P. *from the causes and on the date stated above.*

23A. SIGNATURE: Clark B. Rice M. D.
23B. ADDRESS: 601 North Broadway
23C. DATE SIGNED: 6-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Fort Dupont
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JUN 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

157B

G75628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 776

Registered No. G75628

BIRTH NO. B.C. 1282

1. NAME OF DECEASED (Type or Print): Baby "Girl" Lewis

2. DATE OF DEATH: JUN 17 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. / Mos. / 1 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1709 Barnes St 7704

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored		6.16.49			4 / 35

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Lewis
14. MOTHER'S MAIDEN NAME: Nancy ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Premature
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6.16 1949 *to* 6.17 1949, *that I last saw the deceased alive on* 6.17 1949, *and that death occurred at* 12:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles Workman M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JUN 24 1949
REGISTRAR'S SIGNATURE: Tuttle for Williams, M.D.
25. FUNERAL DIRECTOR:
ADDRESS:

VS 150

Hospital - Disposal

159

Correct age is especial important. Physician please write plainly.

G75629 BALTIMORE CITY HEALTH DEPARTMENT G75629

BIRTH NO. B.C 49-12179 CERTIFICATE OF DEATH 776 Registered No.

1. NAME OF DECEASED (Type or Print) Baby "Boy" Conrad

2. DATE OF DEATH JUN 15 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Dundalk
D. STREET ADDRESS (If rural, give location) 7617 South Dend Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		6-15-49			7 / 42

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME Emaline ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Premature

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-15, 1949, *to* 6-15, 1949, *that I last saw the deceased alive on* 6-15, 1949, *and that death occurred at* 7:42 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Milton Mendlowitz M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 24 1949	Huntington Williams, M.D.		

VS 150

Hospital Disposal

159

Please write the cause of death clearly and legibly. Physician: please write correct age in especially important.

G75630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

7544 Registered No.

G75630

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ruth Reuss

2. DATE OF DEATH JUN 24 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Ohio
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coshocton
D. STREET ADDRESS (If rural, give location) 313 N. Fourth St

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH 11-1-12
9. AGE (In years last birthday) 36
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Reinhold Reuss
14. MOTHER'S MAIDEN NAME Christina Lang

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure

DUE TO (B) Congenital Heart disease

(C) Death followed injection Dicodid

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-20-49 to 6-24-49, *that I last saw the deceased alive on* 6-24-49, *and that death occurred at* 6 10 p m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 6-24-49

24A. ~~BURIAL, CREMATION~~, REMOVAL (Specify) Removal
24B. DATE June 25, 1949
24C. NAME OF CEMETERY ~~OR CREMATORY~~ South Lawn
24D. LOCATION (City, town, or county) (State) Coshocton, Ohio
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR JUN 25 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR William J. Tickner & Sons
North & Pa Aves
Balto. 17, Md. 157E

VS 150

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33

Registered No. G75631

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs Annie Letham Walker

2. DATE OF DEATH June 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Camp Holabird

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Camp Holabird

c. Length of stay in Baltimore 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE RI
B. COUNTY Providence
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pawtucket
D. STREET ADDRESS (If rural, give location) 16 Sykes Ave

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 25 Oct 1872

9. AGE (In years last birthday) 76

If Under 1 Year: Months, Days

If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Shanors Station Penn

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John J. Letham

14. MOTHER'S MAIDEN NAME Annie Cowan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Col Walker ADDRESS Camp Holabird Baltimore md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Apoplexy Thrombosis

DUE TO

(B) Cerebral arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 20, 1949, *to* June 24, 1949, *that I last saw the deceased alive on* June 24, 19 49, *and that death occurred at* 4:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE Ernest Long M. D.

23B. ADDRESS Camp Holabird

23C. DATE SIGNED June 24 '49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify) Burial

24B. DATE June 27, 1949

24C. NAME OF CEMETERY OR ~~CREMATORY~~ Riverside

24D. LOCATION (City, town or county) (State) Pawtucket, R. Island.

DATE RECEIVED BY LOCAL REGISTRAR JUN 25 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR William J. Tickner & Sons ADDRESS North and Pa. Ave. Balto. 17, Md.

VS 150

83B

Correct age is especially important. Physician, please write the causes of death clearly and legibly.

G75632 — BALTIMORE CITY HEALTH DEPARTMENT — G75632

CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Anna Apple

2. DATE OF DEATH: 6/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 60 E. Heath St
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 60 E. Heath St. 23-10

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~ (Specify): Widowed
8. DATE OF BIRTH: 9/4/1882
9. AGE (In years last birthday): 66 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Berges
14. MOTHER'S MAIDEN NAME: Caroline Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Bertha Pilghman 60 E. Heath St

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician: please write correct age is especially important.)

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ — NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: John R Davis M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/27/49
24C. NAME OF CEMETERY or CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Wm Cook Inc. 127 St. Paul St.

VS 151

937

G75633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75633

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Peter Michael Worthington

2. DATE OF DEATH 6/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1506 Eutaw Place

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1506 Eutaw Place 14-0

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH 8/11/1896 | 9. AGE (In years last birthday) 52 | If under 1 Year: Months Days | If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Reporter | 10B. KIND OF BUSINESS OR INDUSTRY Civil Engineering | 11. BIRTHPLACE (State or foreign country) Johnstown Pa | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Richard Worthington | 14. MOTHER'S MAIDEN NAME Rachel O'Brien

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mary Schopf ADDRESS 1506 Eutaw Place

MEDICAL CERTIFICATION

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH 2.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 11, 1949, to June 23, 1949, that I last saw the deceased alive on June 1 1949, and that death occurred at 12:45 A. m., from the causes and on the date stated above.

23A. SIGNATURE Louis T. Davis M. D. | 23B. ADDRESS 1844 W. North Ave | 23C. DATE SIGNED 6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 6/25/49 | 24C. NAME OF CEMETERY OR CREMATORY St. Peters | 24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 25 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Wm. Cook Inc. | ADDRESS 1217 St. Paul St

VS 150

13B

5634

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 3 1

Registered No. G75634

1. NAME OF DECEASED (Type or Print): Mary Rose Stehlik

2. DATE OF DEATH: June 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3605 Woodlea Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 1905 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3605 Woodlea Avenue 27-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
female	white	widowed	March 7, 1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Czechoslovakia	

13. FATHER'S NAME: Joseph Matejka

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No		Mrs. Josephine Scheiner - above

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	2 days
DUE TO (B)	Hypertension	? years.
DUE TO (C)	Arteriosclerosis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 20, 1949 *to* June 22, 1949 *that I last saw the deceased alive on* June 22, 1949, *and that death occurred at* 9:10 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles V. Sewell M. D.	3601 Ailsa Ave.	June 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/25/49	Oak Hill Cemetery	Horner's Lane, Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JUN 25 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street

VS 150

83a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75635

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 G75635 Registered No.

1. NAME OF DECEASED (Type or Print) Aaron Jay Kahn

2. DATE OF DEATH June 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6122 Green Spring
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6122 Green Spring Ave.
c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md.
D. STREET ADDRESS (If rural, give location) 6122 Green Spring Ave. 27-20

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	May 18, 1884	65	1 / 6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman		Baltimore, Md.	U.S.A.

13. FATHER'S NAME Jacob M. Kahn

14. MOTHER'S MAIDEN NAME Bessie Shapiro

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Leonore Kahn	6122 Green Spring Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypertensive Cardio-vascular disease	unknown
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) unknown	
	DUE TO (C) none	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/9, 1946 *to* 6/24, 1949 *that I last saw the deceased alive on* 6/24, 1949, *and that death occurred at* 9:35 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Martin L Sunswick M. D.	1109 St Paul St	6/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 26 49	Baltimore Hebrew	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949	Huntington Williams, M.D.	David Sondheimer Son	1402 Eutaw Place

S-150

93D

G75636

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1544

G75636

Registered No.

1. NAME OF DECEASED (Type or Print): Jeffrey Lynn Appleby

2. DATE OF DEATH: JUN 24 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Harrisburg
D. STREET ADDRESS (If rural, give location): 2700 Derry St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	single	? 1949		4			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Pa	

13. FATHER'S NAME: W. Appleby Sr

14. MOTHER'S MAIDEN NAME: Jessie Phelps

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure

DUE TO

(B) Congenital heart disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-8, 1949 *to* 6-24, 1949, *that I last saw the deceased alive on* 6-24, 1949, *and that death occurred at* 6 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. C. Burkholder M.D.	JOHNS HOPKINS HOSPITAL	6-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/28/49	Rolling Green	Cumberland Co. Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949	Huntington Williams, M.D.	Charles P. Towell	1427 Edmondson Ave

VS 150

157E

Please write the cause of death clearly and legibly. Physician: please write correct age in especially important.

G75637

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75637

1. NAME OF DECEASED (Type or Print): Elizabeth Bessie Stadelman

2. DATE OF DEATH: June 23 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 731 E 30th St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 731 E 30th St

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 731 E 30th St

9 - 0 4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	February 20 1892	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles McComas	Minnie Holstie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	***	***	George V Stadelman	731 E 30th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 Years

DUE TO (B) Chronic Congestive Heart Failure

DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 15, 1949, *to* June 23, 1949, *that I last saw the deceased alive on* May 5, 1949, *and that death occurred at* 7 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sol Smith M. D.	1223 E North Ave	6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 27 1949	Baltimore Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949	Turington Williams M.D.	J Melville Jenkins	2713 Kirk Ave

VS 150

94a

G75638
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

450.0 G75638
Registered No.

1. NAME OF DECEASED (Type or Print): SADIE B. DEUBER

2. DATE OF DEATH: June 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4400 Sidehill RD.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4400 Sidehill Rd. 28-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	July 17, 1866	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home		Baltimore, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel E. Henry	Elizabeth Lowther

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
Non	None	Mrs. Inez S. Abrahams 4400 Sidehill Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized arteriosclerosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept, 1941 *to* June 23, 1949, *that I last saw the deceased alive on* May 27, 1949 *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	3321 Frederick Ave	6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/27/49	Loudon Pk. Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS INC.	North & Pa. Ave. Balto. 17, Md.

VS 150

97

Please write the cause of death clearly and legibly. Physician's special attention is especially important. Please write correct age in especial

G75639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 y 1

G75639 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK D. SOMERS

2. DATE OF DEATH June 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 333 S. Smallwood St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 333 S. Smallwood St. 20 05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	Oct. 2, 1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	--	Baltimore, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Albert Somers	Mollie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
World	I	212-16-8751	Mr. Frank W. Somers	2500 W. Fayette St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — 1 hr

DUE TO

(B) Hypertension; arteriosclerosis

DUE TO

(C) alcoholism, chronic

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1948 *to* June, 1949 *that I last saw the deceased alive on* June, 1949 *and that death occurred at* 6A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Bayless M. D.	1600 Wilkens Ave	24 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/27/49	Balto. Nat'l Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949	Huntington Williams, M.D.	WM. J. TICHNER & SONS INC.	North & Pa. Balto. 17, Md.

VS 150

94a

Correct age is especially important. Physician please write in words.

475640

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

45 0 G75640 Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES F. ROSEWAG

2. DATE OF DEATH: June 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1321 Homestead St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1321 Homestead St. 9-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	divorced	April 10, 1878	71 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Foreman	Paper Box Business	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Paul Rosewag	-

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. Earl O. Rosewag	1321 Homestead St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bleeding from bowel. Cancer of sigmoid

DUE TO

(B) Arteriosclerosis. Senility.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-9, 49, *to* 5-20 49, *that I last saw the deceased alive on* June 1, 49, *and that death occurred at* 3 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert Gurley M. D.	2436 E. Baltimore St	6-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/25/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

97

75641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 4.1 G75641

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN J. BERNARDING

2. DATE OF DEATH June 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Rustless Steel Company

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2627 Mura Street 803

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	May 25, 1915	34		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
crane operator	Rustless Steel	Pittsburg, Pennsylvania	

13. FATHER'S NAME: John Bernarding

14. MOTHER'S MAIDEN NAME: Clara Quallick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Mrs. Matilda Bernarding 2627 Mura St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute congestive heart failure
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Earl L. Koch M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED June 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) — (State)
Burial	6/27/49	Oaklawn Cem.	Balto. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: L. Heeman & Son 6067 Harford Rd.

VS 151

93E

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

FCH 129043

75642

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

171 Registered No. C75642

1. NAME OF DECEASED (Type or Print) Leila Wesley

2. DATE OF DEATH June 23, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue.

c. Length of stay in Baltimore: 7 Years. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 251 S. Broadway, 2-or

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: December 5, 1905
9. AGE (In years last birthday): 43
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10B. KIND OF BUSINESS OR INDUSTRY: Lunch Room

11. BIRTHPLACE (State or foreign country): Miss.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Will Wesley

14. MOTHER'S MAIDEN NAME: Julia Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Records
ADDRESS: ~~Baltimore City Hospitals~~ 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of cervix with widespread Metastasis.
DUE TO

(B)
DUE TO

(C) Subacute Bacterial Endocarditis with Multiple infacts.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5 Mos.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-17, 19 49, *to* 6-23, 19 49, *that I last saw the deceased alive on* 6-23, 19 49 *and that death occurred at* 6:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 6-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/25/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Hayesville
24D. [illegible] County) (State): N. C.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc.
ADDRESS: 1217 St. Paul St.

VS 150

48a

G75643 BALTIMORE CITY HEALTH DEPARTMENT 776 G75643

BIRTH NO. B.C. 49-1296 f CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) BABY GIRL RICHARDS #1 (TWIN)

2. DATE OF DEATH 6/24/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSP.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6 03

D. STREET ADDRESS (If rural, give location) 2126 Orleans St

5. SEX	6. COLOR OR RACE	7. SINGLE, ~~MARRIED, WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
F	W		6/24/49					42

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MARYLAND	

13. FATHER'S NAME MR. FRANCIS d. RICHARDS

14. MOTHER'S MAIDEN NAME EMILY YOVISH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	None	FRANCIS P. RICHARDS	2126 ORLEANS St

MEDICAL CERTIFICATION — CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PREMATURITY (5½ MOS.) — INTERVAL BETWEEN ONSET AND DEATH 42 min.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 24, 1949 *to* June 24, 1949 *that I last saw the deceased alive on* June 24, 1949, *and that death occurred at* 5:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul D'Amours M. D.	BON SECOURS HOSP.	6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)	ADDRESS
BURIAL	6-28-49	MORELAND PARK CEM	5806 HARFORD AVE BALT MD.	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949	Huntington Williams, M.D.	THOS. J. KENNY - Inc.	1600 Hollins St

VS 150

159

Exact age is especially important. Physicians: please write the cause of death clearly and legibly.

G75644 176 G75644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C.49-12965

1. NAME OF DECEASED (Type or Print) Baby GIRL RICHARDS # 2 (TWIN)

2. DATE OF DEATH 6/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSP.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-03
D. STREET ADDRESS (If rural, give location) 2126 Orleans St

5. SEX	6. COLOR OR RACE	7. SINGLE, ~~MARRIED~~, ~~WIDOWED, DIVORCED (specify)~~	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W		6/24/49					2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	MARYLAND	

13. FATHER'S NAME MR. FRANCIS J. RICHARDS

14. MOTHER'S MAIDEN NAME EMILY YOVISH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO	NO	NONE

17. INFORMANT Francis J. Richards ADDRESS 2126 Orleans St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) PREMATURITY (5½ MOS.)	2 MIN.
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 24, 1949 *to* June 24, 1949 *that I last saw the deceased alive on* June 24, 1949, *and that death occurred at* 4:47 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul D. Dramuro M. D.	BON SECOURS HOSP.	6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	6-25-49	Mountland Park Cem.	5806 Harford Ave Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949	Huntington Williams, M.D.	Thos. J. Kenny-Inc.	1600 Hollins St

VS 150

159

Please write the cause of death clearly and legibly. Physician: please write the exact age in especially important.

G75645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

G75645 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) OSCAR WARD EDWARDS

2. DATE OF DEATH June 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 506 N. Howard St. (Stanley Hotel) 11-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	W	D	1/9/1912	37				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Western Electric Co.	Virginia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Oscar B. Edwards	Blanche Veazey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW #2		Family	I734 Homestead St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
M.D.		June 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	6/27/49	Baltimore National	5501 Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949	Huntington Williams, M.D.	James L. McCully	130 E. Fort Ave.

VS 151

839

Please write the cause of death clearly and legibly. Correct age is especially important. Physician:

G75646
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75646

1. NAME OF DECEASED (Type or Print) GEORGE REPP

2. DATE OF DEATH June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

C. Length of stay in Baltimore — Yrs. Life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 803 South Dallas Street 3-02

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Jan 15 1883
9. AGE (In years last birthday): 66 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Potter
10B. KIND OF BUSINESS OR INDUSTRY: Pottery
11. BIRTHPLACE (State or foreign country): Balto Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Leonhard Repp
14. MOTHER'S MAIDEN NAME: Mary Stumpner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. unknown
17. INFORMANT: Miss Matilda Zukowski — ADDRESS: Belcamp Md

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial degeneration
DUE TO
(B) Malnutrition

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earle L Repp M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED June 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 28 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel.
24D. LOCATION (City, town, or county) (State): O Donnell St. Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 25 1949
REGISTRAR'S SIGNATURE: Earlington for Williams, M.D.
25. FUNERAL DIRECTOR: Howard N. Blight Jr.
ADDRESS: 6009 Harford Rd 937 Balto. 14, Md

VS 151

Please write the causes of death clearly and legibly. Physician: please write the correct age is especially important.

G75647

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

18 Registered No. G75647

1. NAME OF DECEASED (Type or Print) Dr. Edgar Roland Andrews

2. DATE OF DEATH June 23.1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2600 Frederick Rd.

c. Length of stay in Baltimore life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2600 Frederick Rd. 20-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	widowed	Jan.4.1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pharmacist	Drug Store	Baltimore Md	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
David Andrews	Anna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	212-18-7607	Mr.Robert M.Baer. Balto.Life Ins.Bl

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Bladder — INTERVAL BETWEEN ONSET AND DEATH: 20 Months

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 48, 1949 *to* June 23, 1949, *that I last saw the deceased alive on* June 23 1949, *and that death occurred at* 3 55 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Glassman M. D.	2687 Mayfield Ave	June 24 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June.25.1949	Loudon Park Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 25 1949	Kenneth Williams, M.D.	HENRY SANDER & SONS, INC. Baltimore Md.

VS 150

52B

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G75648

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75648

1. NAME OF DECEASED (Type or Print) MRS. MOLLIE C. SCHLEUNES

2. DATE OF DEATH 6/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSP

c. Length of stay in Baltimore Yrs. LIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 12-04
D. STREET ADDRESS (If rural, give location) 3226 AUCHENTOROLY TERRACE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	MARRIED	MARCH 20 1894	55				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		Md	USA

13. FATHER'S NAME CHARLES KIMPEL

14. MOTHER'S MAIDEN NAME MOLLIE SCHEULER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
nor		None	Mr. Irwin Schleunes	3226 Auchentoroly Terrace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIOSCLEROTIC HEART DISEASE
DUE TO GRADE IV DECOMPENSATION

(B) PULMONARY EMBOLISM
DUE TO RT BASE

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/2, 19 49 *to* 6/24, 19 49, *that I last saw the deceased alive on* 6/24, 19 49, *and that death occurred at* 3:00 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald W. Winter M. D.	Church Home + Hosp.	6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY?	24D. LOCATION (City, town, or county) (State)
Burial	6/27/49	Lorraine Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949 VS 150	Huntington Williams, MD	WM. J. TICKNER & SONS INC.	North & Pa. Ave. Baltimore 17, Md.

937

Correct age is especially important. Physician: please write the CAUSE OF DEATH clearly and fully.

G75649 BC#1259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. [illegible] Registered No. G75649

1. NAME OF DECEASED (Type or Print): Kirk Howard Heald

2. DATE OF DEATH: 6-25-49 1:35 A.M.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2025 W. Fayette St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

C. Length of stay in Baltimore: 1 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 5,
D. STREET ADDRESS (If rural, give location): 507 N. Lakewood Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M.	W.	Single	6-23-49			1	18	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore Md.	

13. FATHER'S NAME: Howard Berry Heald

14. MOTHER'S MAIDEN NAME: Doris Martha Schurman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Atelectasis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-23, 1949 *to* 6-25, 1949 *that I last saw the deceased alive on* 6-25, 1949 *and that death occurred at* 1:35 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	Bon Secours Hosp	6-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/28/49	New Cathedral Cem	Frederick Ave Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949	[signature] Huntington Williams, M.D.	Thos. J. Kenny-Inc.	1600 Hollins St

VS 150

1619

Exact age is especially important. Physician: please write the causes of death clearly and legibly.

G75650 (1)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75650 (2) Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) — Anna E. Smith

2. DATE OF DEATH — 6/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — 3120 Georgetown Rd.

C. Length of stay in Baltimore — 65 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Baltimore
D. STREET ADDRESS (If rural, give location) — 703 Eaton Ave 20-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	1/1/1869	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work	at Home	York Pa.	U S A

13. FATHER'S NAME — Unknown

14. MOTHER'S MAIDEN NAME — Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
✓	—	✓

17. INFORMANT — Mrs Mary J. Kendall ADDRESS 3120 Georgetown

MEDICAL CERTIFICATION

(Please write clearly and use ink. Physician—please write the cause of death in plain terms. Do not use abbreviations or symbols. Do not state mode of dying, such as heart failure, asthenia, etc. Please do not report symptoms, such as pain, weakness, etc. Please do not report conditions which did not cause death. Please be specific as to the cause of death. Please report the duration of each cause. Please fill in items 19 to 21 if applicable. Please sign certificate. Please report date signed. Please be sure that every applicable item is properly completed. Please be sure that the certificate is complete before it is filed. Please be sure that the certificate is filed promptly. Please be sure that the certificate is filed with the proper authority. Please be sure that the certificate is filed in the proper place. Please be sure that the certificate is filed by the proper person. Please be sure that the certificate is filed in the proper manner. Please be sure that the certificate is filed in the proper form. Please be sure that the certificate is filed in the proper time. Please be sure that the certificate is filed in the proper way. Please be sure that the certificate is filed in the proper manner. Please be sure that the certificate is filed in the proper form. Please be sure that the certificate is filed in the proper time. Please be sure that the certificate is filed in the proper way.)

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of rt. ovary — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO
(B)
DUE TO
(C) Generalized Atherosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 19, 1949 *to* June 25, 1949 *that I last saw the deceased alive on* June 24, 1949 *and that death occurred at* 3:39 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr Callens M. D.	3321 Frederick Ave	6/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/28/49	St Augustines	Elkridge Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949	Huntington Williams, M.D.	John J. Cowan & Son	49a Hollins St.

VS 150

G75651

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

53 G75651

Registered No.

1. NAME OF DECEASED (Type or Print): Marie A. Davis

2. DATE OF DEATH: 6/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1315 Gable Ave

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1315 Gable Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	2/18/1900	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home Work	at Home	Baltimore Md.	U S A

13. FATHER'S NAME: Christian Schorr

14. MOTHER'S MAIDEN NAME: Josephine Pehringer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	Mr Geo. H. Davis	1315 Gable Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Sigmoid Colon with generalized Metastases — INTERVAL BETWEEN ONSET AND DEATH: 7 mos

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
@ 11/1/48	Carcinoma of Sigmoid Colon & extensive Metastases	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from November 13, 1947, to June 24, 1949, that I last saw the deceased alive on June 21, 1949, and that death occurred at 9 30 P m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Guthrie Rossberger M. D.	3411 Washington Blvd Balto. 30	6/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/27/49	Mt Olivet Cem	2930 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949	Huntington Williams, M.D.	John J. Cowan & Son	Collins St. 46E

VS 150

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G75652 ✓ G75652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie B Lounge

2. DATE OF DEATH: June 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1816 N Dallas St
C. Length of stay in Baltimore: 80 Yrs. 2 Mos. 5 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1816 N. Dallas St. 8-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	April 9, 1869	80 yrs	2	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Freshline
14. MOTHER'S MAIDEN NAME: Josephine Hickey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT: Mrs. Henry A. Lounge ADDRESS 1816 N. Dallas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chr. Nephritis
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Hypertension Cord with Vascular disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 11 30 1948 *to* JUN 24, 1949, *that I last saw the deceased alive on* JUN 24, 1949, *and that death occurred at* 11 30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Ruth J Himzey M. D.
23B. ADDRESS: 2700 Harford Rd
23C. DATE SIGNED: JUN 25 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 27/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery
24D. LOCATION (City, town, or county) (State): Harford Rd Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUN 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elmer W. Conklin ADDRESS 924 E. Lagonda St.

937

Please write the cause of death clearly and legibly. Physician: please write with ink. Special care is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO G75653 — 1 Registered No. G75653

1. NAME OF DECEASED (Type or Print): Clarence E. Williams — 2. DATE OF DEATH: June 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Earleigh Heights
D. STREET ADDRESS (If rural, give location): Severna Park P.O. Box 357

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	married	April 23, 1915	34		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bread & Milk Salesman	George Pumphrey	Sidney, Nebraska	

13. FATHER'S NAME: Frank E. Williams
14. MOTHER'S MAIDEN NAME: Olena Olson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured neck.
DUE TO Fractured pelvis.
(B) Fractured ribs.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street	Mulberry and ~~S.~~ Monroe

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
June 23, 1949 6:30 A.M.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Truck and Auto Collison

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George L. Merrill M.D.		6/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 27, 1949	Glen Haven	Glen Burnie

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JUN 26 1949	Huntington Williams, M.D.	Thomas W. Singleton 1710

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75654 ✓ X G75654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Roberts, Mr. Harry

2. DATE OF DEATH 26 June 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home + Hospital

c. Length of stay in Baltimore 17 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived at time of death; if institution: residence before admission)
A. STATE Maryland B. COUNTY Washington
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hagerstown
D. STREET ADDRESS (If rural, give location) Route 3 Hagerstown

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	March 4, 1887	62	3 / 21	2 /

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm laborer	farming	Maryland	U.S.A.

13. FATHER'S NAME Mr. Wm. Roberts

14. MOTHER'S MAIDEN NAME Rebecca Monlworth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		The deceased	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

DUE TO

(B) Renal failure — 36 hrs.

DUE TO Following Miles resection

(C) for Carcinoma of sigmoid

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-18-49	Carcinoma of sigmoid colon	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9 June, 1949, *to* 26 June, 1949, *that I last saw the deceased alive on* 26 June, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
F. Robert Haare M. D.	Church Home & Hosp	6-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-28-49	Pine Grove	Mt. Airy Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 26 1949	Huntington Williams, M.D.	B. M. Walz	Winfield, Md.

VS 150

46E

Correct age is especial important. Physician: please write the exact age in years, or if under one year, in months, days, hours or minutes, as the case may be. Do not write "infant" or "child" or "adult" or "old man" or "old woman" or "baby".

BIRTH NO. B.C. 125-46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 772.5 G75655

1. NAME OF DECEASED (Type or Print) Louise E. Liz Wingate

2. DATE OF DEATH 6/25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1135-Gilmor 16-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	S	6/24-49	0 days		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		1135-Gilmor	

13. FATHER'S NAME James Wingate

14. MOTHER'S MAIDEN NAME Louise E. Wingate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mother	1135-Gilmor

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malnutrition DUE TO Premature Birth

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/24 *to* 6/25-49 *that I last saw the deceased alive on* 6/25-49 *and that death occurred at* 6 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	2135 Druid Hill	6/25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/27/49	Mt. Calvary	A.A.Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 26 1949	Thurlow for Williams, M.D.	Metropolitan Funeral Home Inc.	927-N. Mount St.

VS 150

159

G75656 G75656

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. G75656 Registered No. 43

1. NAME OF DECEASED (Type or Print): PHOEBE B. CLARK
2. DATE OF DEATH: JUNE 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wallace Nursing Home 2075 Rockrose Avenue
C. Length of stay in Baltimore: 15 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3638 Hickory Avenue 13-06

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: August 3-1879
9. AGE (In years last birthday): 69
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Masemore
14. MOTHER'S MAIDEN NAME: Mary Bull
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Dolly C. Long ADDRESS: 5208 East Avenue

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Correct age is especially important. Physician:)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 wks
DUE TO
(B) Hypertension C-V-D — 2
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes Mellitus — 15 yrs+

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* JUNE 23 1949, *to* JUNE 24, 1949, *that I last saw the deceased alive on* JUNE 23, 1949, *and that death occurred at* 2:05 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: John M. Scott M. D.
23B. ADDRESS: E Longwood Rd
23C. DATE SIGNED: June 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 27-1949
24C. NAME OF CEMETERY OR CREMATORY: Riverburg
24D. LOCATION (City, town, or county) (State): Baltimore Co. Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JUN 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home
ADDRESS: 360 Falls Road

61

G75657 ✓ G75657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 701

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dorothy A. Edwards

2. DATE OF DEATH: June 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 607 N. Bouldin St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 607 N. Bouldin Street 26 10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	October 4, 1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph C. Schaefer	Margaret Wagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Hodgkin's Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO:
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	None	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
On.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 4, 1949, *to* June 25, 1949 *that I last saw the deceased alive on* June 25, 1949, *and that death occurred at* 12:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Francis J. Damuszeski, M.D.	540 N. Lenwood	6-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/27/49	Holy Redeemer Cemetery	4430 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 26 1949	[illegible]	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street

44B

G75658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 34

G75658 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH H. ATHMAN

2. DATE OF DEATH June 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTIMORE GENERAL HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 3116 NORMOUNT AVE. 16-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M. ♂	W	MARRIED	Feb. 23, 1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAFFIC MANAGER, DEPT. STORE

10B. KIND OF BUSINESS OR INDUSTRY DEPT. STORE

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME HENRY ATHMAN.

14. MOTHER'S MAIDEN NAME ELIZABETH. RUHBERG.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 213-03-6184

17. INFORMANT MARGARET A. ATHMAN ADDRESS 3116 Normount Ave

MEDICAL CERTIFICATION

Please write plainly. Physician: It is especially important that the cause of death clearly and fully stated.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pyelonephritis & cystitis
DUE TO

(B) Sub-acute combined sclerosis of brain & spinal cord
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT. SUICIDE. HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-12, 1949 *to* 6-24, 1949 *that I last saw the deceased alive on* 6-24, 1949 *and that death occurred at* 4:55 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Katherine V. Kemp M. D.	West Balto. Gen. Hosp.	6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-27-1949	Holy Redeemer	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 26 1949	Huntington Williams M.D.	J. Howard Strong	3207 W. North Ave

$2

CERTIFICATE CORRECTED 2-8-49

G75659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75659 Registered No. 32288

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MISS Louise A. MARTIN

2. DATE OF DEATH 6-23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Catonsville
D. STREET ADDRESS (If rural, give location) 17 Delrey Ave. Catonsville

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	single	July 31, 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chief Clerk	U.S. Government	Maryland	

13. FATHER'S NAME Louis Martin

14. MOTHER'S MAIDEN NAME Louise McLaughlin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MASSIVE SUBARACHNOID HEMORRHAGE

DUE TO

(B) I SUBDURAL HEMATOMA

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/9/, 1949 *to* 6/23, 1949 *that I last saw the deceased alive on* 6/23, 1949, *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John N. Shaw M. D.	St. Agnes Hosp.	6/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/27/49	St. Mary's	Pikesville, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 25 1949	Washington Williams, M.D.	George R. Farley.	Fulton Ave & Fayette St

83a

Please write clearly and legibly. Physician: please write the cause of death clearly and legibly. Be sure to state age if especially important.

G75660 Fuka ✓ G75660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Fuka

2. DATE OF DEATH June 23/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2135 Jefferson st

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2135 Jefferson st 6-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	Dec. 30, 1890	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter

10B. KIND OF BUSINESS OR INDUSTRY Boat Painting

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Fuka

14. MOTHER'S MAIDEN NAME Catherine Couch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) 1st World War

16. SOCIAL SECURITY NO. 217-01-7781

17. INFORMANT Lilly Konarski ADDRESS Millersville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ca of the Pyloric

DUE TO Enl of the Stomach

(B) Liver.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

19A. DATE OF OPERATION May - 49

19B. MAJOR FINDINGS OF OPERATION Ca of Stomach & Liver

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1 '49, to 6-22 '49, that I last saw the deceased alive on 6-22 '49, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE Fred. Reynolds Jr M.D.

23B. ADDRESS 600 N Patterson Park Ave

23C. DATE SIGNED 6-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE June 27/49

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer

24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949

REGISTRAR'S SIGNATURE Penelope for Williams, M.D.

25. FUNERAL DIRECTOR Frank Brachbar ADDRESS 900 Chester

JUN 28 1949 150

46B

G75661

G75661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 203

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Anna Lesky or Lifiecki

2. DATE OF DEATH 6/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Univ. Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp. Green & Lombard st.
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 921 Argonne Dr. 9 01

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 6-9-1875
9. AGE (In years last birthday) 74
If Under 1 Year — Months / Days
If Under 24 Hours — Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Emanl Klein
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Lillian Heinkam ADDRESS 92 Argonne Dr.

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

16. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac failure
DUE TO
(B) Subarachnoid hemorrhage
DUE TO
(C) Multiple Myelomas

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from 6/1/49, 1949, to 6/24/49, 1949, that I last saw the deceased alive on 6/24/49, 19___, and that death occurred at 8 45 a.m., from the causes and on the date stated above.

23A. SIGNATURE Howard E Hall M. D.
23B. ADDRESS Univ. Hosp.
23C. DATE SIGNED 6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6-27-49
24C. NAME OF CEMETERY OR CREMATORY Holy Rosary
24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 26 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR John A. Moran
ADDRESS 3000 E Balt St.

55E

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

BIRTH NO. 5662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75662

1. NAME OF DECEASED (Type or Print): Stephen Lovell

2. DATE OF DEATH: June 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Spurg - Hal 3

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Va
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Martinsville Rt 2
D. STREET ADDRESS (If rural, give location):

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: 2-28-46
9. AGE (In years last birthday): 3 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Lovell
14. MOTHER'S MAIDEN NAME: Virginia Mills

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

Please write the cause of death clearly and correct age is especially important. Physician:

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure following
DUE TO
(B) Cerebral thrombosis
DUE TO
(C) Congenital heart disease

INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 6/25/49
19B. MAJOR FINDINGS OF OPERATION: Pathology of Heart
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about house, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from 6-24-, 1949 to 6-26-, 1949 that I last saw the deceased alive on 6-26-1949, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE: W. C. Sanford M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 6/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 28/49
24C. NAME OF CEMETERY OR CREMATORY: Private Cemetery
24D. LOCATION (City, town, or county) (State): Martinsville Va

DATE RECEIVED BY LOCAL REGISTRAR: JUN 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John D. Mitchell & Sons
ADDRESS: 1900 Eutaw Place

157E

G75663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1 G75663

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Marie Klein

2. DATE OF DEATH: 6-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Seton Institute

c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8 19-1
D. STREET ADDRESS (If rural, give location): 502 Reisterstown Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	white	widowed	4-21-89	60	2	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	T. MARYLAND	U.S.A.

13. FATHER'S NAME: Anthony J. Voith

14. MOTHER'S MAIDEN NAME: Mary Protzman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	?

17. INFORMANT: The Seton Institute, ADDRESS: Balto. 15, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic hypertensive heart disease; coronary occlusion
DUE TO
(B) General arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: 4 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Manic-depressive psychosis, manic state

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 21, 19 49 to June 23, 19 49 *that I last saw the deceased alive on* June 23, 19 49, *and that death occurred at* 2:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter D. Talbert's M. D.	3703 Clarke Lane	June 23, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/27/49	Holy Redeemer	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	[illegible] for Williams, MD	Lilly & Zeiler	403 S. Wolfe

VS 150

937

Please write the cause of death clearly and legibly. Physician: please write in ink. Correct age is especially important.

G75664

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

H63

Registered No. G75664

1. NAME OF DECEASED (Type or Print) GERTRUDE KITOWSKI

2. DATE OF DEATH 6/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 2227 Eutaw Place 13-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	M	12/5/1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	S. C.	

13. FATHER'S NAME Thomley D. Harris

14. MOTHER'S MAIDEN NAME Nora G. Hendrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, upon unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Henry J. Kitowski	2227 Eutaw Place

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Infarction
DUE TO Embolism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Thrombophlebitis - right leg
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Mild Diabetes - Obese

(INTERVAL BETWEEN ONSET AND DEATH)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/16, 1949 *to* 6/25, 1949 *that I last saw the deceased alive on* 6/25, 1949 *and that death occurred at* 2:25 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harold Sussman, M. D.	Sinai Hospital	6/25/49

24A. BURIAL: ~~CREMATION, REMOVAL (Specify)~~	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	6/28/49	Moreland Park	Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 150

61

Please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and correct age is especially important.

G75665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75665 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Florence Olevia Robier

2. DATE OF DEATH June 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1400-04 W. Lexington St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Aged Women's & Aged Men's Homes

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1404 W. Lexington St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (Last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	August 1, 1861	87	10	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Inmate	Home for Aged	Maryland	

13. FATHER'S NAME Thomas M. Robier

14. MOTHER'S MAIDEN NAME Hannah Parrott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
None			L. H. Read	1400-04 W. Lexington St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Thrombosis	2 weeks
	DUE TO (B) Cerebral arteriosclerosis	years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) Senile Dementia	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1949 *to* June 24, 1949 *that I last saw the deceased alive on* June 23, 1949 *and that death occurred at* 8:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wellwood Elwood Day M. D.	4-E-33rd St	June 25, 1949

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town or county) (State)
Burial	6/27/49	Western	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	Wm. Cook & Inc.	1217 St. Paul St.

VS 150

83B

5666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17 Registered No. 675646

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Miss Evelyn Halbert

2. DATE OF DEATH 26 June 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 308 E North Ave 04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	White	Single	Oct 16 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE		Baltimore Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward L Halbert	Georgia Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		NONE	Elizabeth H Halbert	308 E North Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized peritonitis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Pseudomucinous adenocarcinoma of ovary

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
17 June 1949	Generalized peritonitis; Carcinoma of ovary	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9 June, 1949 *to* 26 June, 1949 *that I last saw the deceased alive on* 26 June, 1949, *and that death occurred at* 5:10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. F. McGoogan M. D.	Maryland General Hospital	27 June 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/29/49	Green Mount	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	Wilhelm & Son	1217 Eutaw Pl

VS 150

49a

...correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 31

G75667

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): John W Wilson

2. DATE OF DEATH: June 24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 213 S Spring Ct

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 213 S Spring Court B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 3-01
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	married	Feb 13 1875	74	4	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter		Baltimore	

13. FATHER'S NAME: John W. Wilson

14. MOTHER'S MAIDEN NAME: Mary Ann Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Miss Bagel ADDRESS: 713 N Broadway

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician: please write correct age in especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage
DUE TO arteriosclerotic hypertension
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* September, 1947 *to* June 24th, 1949, *that I last saw the deceased alive on* June 24th, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H Trongott M. D.	1623 E. N. Avenue	June 25th 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/26/49	Baltimore	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	Wilbert Funeral Home	2600 Eutaw St.

JDHS 150

830

G75668

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75668

1. NAME OF DECEASED (Type or Print) MR. FREDERICK CONRAD NIES

2. DATE OF DEATH 6-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital
c. Length of stay in Baltimore 48 Yrs. 9 Mos. 24 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2019 Eastern Avenue 2-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	10-1-1900	48	9	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrical Engineer		Maryland	U.S.A.

13. FATHER'S NAME Frederick Nies

14. MOTHER'S MAIDEN NAME Kate Unger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. F. C. Nies ADDRESS 2019 Eastern Ave, Balt

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Ebullition, left face — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Radiation Agranulocytosis — 7 weeks

DUE TO

(C) Generalized Lymphosarcoma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		NO X

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-21 1949, *to* 6-24, 1949 *that I last saw the deceased alive on* 6-24 1949, *and that death occurred at* 1:45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	Union Memorial Hospital	6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 28/49	St Stanislaus	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	Fred W Ozazewski	930 Eastern Ave

VS 150

55E

Exact age is especially important. Physician: please write the cause of death clearly and legibly.

G75669 3714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75669

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Carson Bradford

2. DATE OF DEATH June 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Med. Marking 3

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 2 Weeks. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Fla
b. COUNTY Dade
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Miami Beach
d. STREET ADDRESS (If rural, give location) 850 E. DeLado Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	2-18-91	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Builder	Builder	Penn	U.S.

13. FATHER'S NAME Jake Bradford

14. MOTHER'S MAIDEN NAME Mary Carson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	No	?

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician: please write correct age if special. Important.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO

(B) Coronary artery arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-13- , 19 49 *to* 6-26 , 19 49 *that I last saw the deceased alive on* 6-26 , 19 49 *and that death occurred at* 7:45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. Carlson M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-27-49	Woodlawn	Miami - Florida

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	Stewart Morris	Balto.

VS 150

94a

G75670

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75670 Registered No.

1. NAME OF DECEASED (Type or Print): MIRIAM SCHNEIDERMAN

2. DATE OF DEATH: 6-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1730 East Baltimore St
c. Length of stay in Baltimore: 16 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-05
D. STREET ADDRESS (If rural, give location): 1730 E Baltimore St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow		71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Russia	

13. FATHER'S NAME: David

14. MOTHER'S MAIDEN NAME: Getta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			David Schneiderman	1730 E Balto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B) Senile Arteriosclerosis — 10 yrs
DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 15, 1949 *to* June 25, 1949, *that I last saw the deceased alive on* June 25, 1949, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.		

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-27-49	Adas Israel	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Tuttington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

937

G75671 G75671

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Margaret R.Horner**

2. DATE OF DEATH **June 26/49**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **3417 Leverton Ave.**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **--**
C. Length of stay in Baltimore **45yrs** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY **3417 Leverton Ave. 76-08**
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Balto. Md.**
D. STREET ADDRESS (If rural, give location) **3417 Leverton Ave.**

5. SEX **Male**
6. COLOR OR RACE **White**
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Widow**
8. DATE OF BIRTH **Nov.25,1877**
9. AGE (In years) last birthday) **71** (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) **England**
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME **John Horner**
14. MOTHER'S MAIDEN NAME **Sarah--**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT **Sylesverter Horner, 3417 Leverton Ave** (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: Yrs or FEB. 26, 1949

DUE TO
(B) ARTERIOSCLEROSIS, GENERALIZED — 10 yrs.

DUE TO
(C) PERNICIOUS ANEMIA — 10 yrs.

II
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* FEB. 26 1949 *to* JUNE 26 1949 *that I last saw the deceased alive on* JUNE 27 1949 *and that death occurred at* 3.35A m., *from the causes and on the date stated above.*

23A. SIGNATURE **[illegible]** M. D.
23B. ADDRESS **121 S. HIGHLAND AVE**
23C. DATE SIGNED **6/26/49**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial**
24B. DATE **June 29/49**
24C. NAME OF CEMETERY OR CREMATORY **Trinity Cem.**
24D. LOCATION (City, town, or county) (State) **Balto. Md.**

DATE RECEIVED BY LOCAL REGISTRAR **JUN 27 1949**
REGISTRAR'S SIGNATURE **[illegible]**
25. FUNERAL DIRECTOR, ADDRESS **Philip Stewart Sons 2024 Orleans St**

VS 150

838

75672

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13 G75672
Registered No.

1. NAME OF DECEASED (Type or Print): August Witt

2. DATE OF DEATH: 6-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq Hosp.

c. Length of stay in Baltimore: 55 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Raspeburg
D. STREET ADDRESS (If rural, give location): 437 Whitemarsh Rd.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify)
8. DATE OF BIRTH: Dec 23, 1860
9. AGE (In years last birthday): 88
If Under 1 Year: Months 6, Days 3
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Farmer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Frieda ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

(B) Hypertensive C.V. Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
yrs

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-24, 1949, *to* 6-26, 1949, *that I last saw the deceased alive on* 6-26, 1949, *and that death occurred at* 8½ a m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. J. Laham M. D.
23B. ADDRESS: Franklin Sq. Hospital
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 6/29/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lassahn Funeral Home
ADDRESS: 7401 Belair Rd.

VS 150

-93D-

G75673

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

17 1 G75673

Registered No.

1. NAME OF DECEASED (Type or Print) MARGARET PAULINE WILLIAR

2. DATE OF DEATH June 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3905 Greenmount Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3905 Greenmount Ave. 9-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	June 27, 1888	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home	-	Pa.	USA

13. FATHER'S NAME: William H. Jamison

14. MOTHER'S MAIDEN NAME: Laura Diffenderfer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		None

17. INFORMANT — ADDRESS: Mrs. W. Raul Reynolds 3905 Greenmount Ave.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Correct age is especially important. Physician please write

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Cervix with generalized Metastasis. — INTERVAL BETWEEN ONSET AND DEATH: 18 mo.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JUNE 21, 1949, *to* JUNE 24, 1949, *that I last saw the deceased alive on* JUNE 24, 1949, *and that death occurred at* 7:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lloyd E. Saylor M. D.	3902 Greenmount Ave.	JUNE 25 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/27/49	Western Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS INC.	North & Pa. Baltimore 17 Md.

VS 150

48a

G75674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

143 Registered No. G75674

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Stow Finlayson Sr.

2. DATE OF DEATH 6/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 619 Rosedale st.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 619 Rosedale st. 16-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	Jan. 1, 1886	63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Life Insurance	Phila. Pa.	U.S.A.

13. FATHER'S NAME Lewis Finlayson

14. MOTHER'S MAIDEN NAME Sarah Ann Stow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	215-12-7626	Mrs. Elizabeth Finlayson	Above

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cardiac insufficiency	
	DUE TO (B) Arteriosclerotic hypertensive cardio	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO vascular disease	several yrs.
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Cerebral hemorrhage	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/23/ , 1948, *to* 6/23/ , 1949, *that I last saw the deceased alive on* 6/23 , 1949, *and that death occurred at* 11.30 PM *from the causes and on the date stated above.*

23A. SIGNATURE	M. D.	23B. ADDRESS	23C. DATE SIGNED
George A. Kemp		3030 Edmondson Avenue	6/24/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/27/1949	Woodlawn	Woodlawn, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Wellington Williams, M.D.	Wm. J. Tickner & Sons Inc.	North & Pa. Ave. Baltimore 17, Md.

VS 150

937

G75675

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

G75675
Registered No.

1. NAME OF DECEASED (Type or Print) John Hill

2. DATE OF DEATH 6/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 32 N. Bentalou St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	Aug 7/1885	63 64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Boiler Maker Layouter	B+O R.R.	Baltimore Md	

13. FATHER'S NAME James A. Hill

14. MOTHER'S MAIDEN NAME Sarah Reisinger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Rebecca Hill	32 N Bentalou St

MEDICAL CERTIFICATION

Please write the cause of death clearly and completely. Physician's signature is especially important. Do not abbreviate.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO

(B) Embolism — 8 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Hypertensive CVD c Auric Fib. — 6 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hardening of Arteries — 13 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/6/49		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 25 1949 *to* June 26, 1949, *that I last saw the deceased alive on* June 26, 1949, *and that death occurred at* 5:12 p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leslie Steinberg M.D.	Sinai Hosp.	6/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 29/1949	Lorraine	Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Williams, MD	Harry Hellmann	4204 Ridgewood Ave

VS 150

937

G75676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

581.0 G75676 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles M. Hughes

2. DATE OF DEATH 6-24-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 709-Sarah Ann St. 4-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Negro		3-11-99	50				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis of liver
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-11 1949 *to* 6-24 1949 *that I last saw the deceased alive on* 6-24 1949 *and that death occurred at* 4:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
J. E. Brady Jr M. D.	Provident Hosp.	6-24-49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-27-49	Arbutus Memorial Park	Arbutus Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 27 1949	[redacted]	Rayner Sanders 1412 E. Preston St

VS 150

124B

G75677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75677

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clarence Barnes

2. DATE OF DEATH JUN 23 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-07
D. STREET ADDRESS (If rural, give location) 210 4 N. Smallwood St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	married	4/2/1900	49				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
machinist Helper	(Dry Dock)	Greenville, N.C.	U.S.A.

13. FATHER'S NAME Samuel Barnes

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-03-5395

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: hours.

DUE TO

(B) Hypertension — years.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO. [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 6-23, 1949 *to* 6-23, 1949 *that I last saw the deceased alive on* 6-23, 1949 *and that death occurred at* 6:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Anthony J. Zap M. D.	JOHNS HOPKINS HOSPITAL	6-25-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/27/1949	Arbutus Mem. Pk.	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave

VS 150

83a

Correct age is especially important. Physician: please write clearly and fully.

G756?8

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50.1 G756?8 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Walsh

2. DATE OF DEATH June 24, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes' Hospital

c. Length of stay in Baltimore — Yrs. / Mon. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-14
d. STREET ADDRESS (If rural, give location) 4405 Kitty Lane

5. SEX M
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 11-18-1883
9. AGE (In years last birthday) 65 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Walsh - dead
14. MOTHER'S MAIDEN NAME Ellen McClair dec'd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) GENERALIZED PERITONITIS
DUE TO ACUTE APPENDICITIS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) HYPERTENSIVE ARTERIO SCLEROSIS
DUE TO CARDIO-VASCULAR DISEASE
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 6/24/49
19B. MAJOR FINDINGS OF OPERATION ACUTE APPENDIX - PARALYTIC ILEUS
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/18, 1949 *to* 6/24, 1949, *that I last saw the deceased alive on* 6/24, 1949 *and that death occurred at* 6:35 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE John W. Shaw M. D.
23B. ADDRESS St. Agnes Hosp.
23C. DATE SIGNED 6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/28/49
24C. NAME OF CEMETERY OR CREMATORY New Cathedral
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR JUN 27 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Paul E. Lehrenmeyer
ADDRESS 3615-17 Chesterfield Ave.

VS 150

121

BIRTH NO. 25679

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 25679

1. NAME OF DECEASED (Type or Print): HARRY T. LAWRENCE

2. DATE OF DEATH: 6-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HOUSE OF OUR LADY 1302 W. LEXINGTON ST
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 335 WARREN AVE.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	SINGLE	9-11-1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
STEEL WORKER	STEEL	FORK, MD.	

13. FATHER'S NAME: JOHN M. LAWRENCE

14. MOTHER'S MAIDEN NAME: SARAH E. JENKINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	214-01-4015	MRS LESHER B. RITTENHOUSE	335 WARREN AVE.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cardio Vascular Disease	?
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 22, 1949 *to* June 24, 1949 *that I last saw the deceased alive on* June 24, 1949, *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Glissman M. D.	753 W. Fayette St	June 26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	6-28-49	PROSPECT HILL	TOWSON, MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	JOHN F. DEMUS, INC	715 LIGHT ST -30

VS 150

937

5680 N-T. 8273 ✓ 59-

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75680 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution 2212 N Monteford
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 6-03
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 Monford
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janie Streeter Streets

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Allen

13. Birthplace NC

MOTHER 14. Maiden Name Daniel

15. Birthplace NC

16 (a) Informant Parker Streeter

(b) Address 2212 N Monford Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-49 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Halethorpe

18 (a) Funeral director A Halstead

(b) Address 908 Fremont Ave Baltimore Md

JUN 27 1949 (Date received) (Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1949 at 7 35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1949 to 6-24 1949 and that I last saw her alive on 6-24 1949.

Immediate cause of death Uremia — Duration 3-4 days

Due to Chr. Glomerular Nephritis — Duration Unkn

Due to — Duration

Other Conditions Hypertension — Duration Unkn

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Garland Shirell M.D.

Address 902 W. Franklin Date signed 6-27-49

1310

75681 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163 G75681 Registered No.

1. NAME OF DECEASED (Type or Print) Emilie Thomas

2. DATE OF DEATH June 25 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3104 Auchentoroly Ter.

C. Length of stay in Baltimore 60 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Balto. (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 3104 Auchentoroly Ter. 13-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	Single	May 15 1871	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nurse Retired	Private	Germany	

13. FATHER'S NAME
Carl Thomas

14. MOTHER'S MAIDEN NAME
Henrietta Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		None

17. INFORMANT Julia Thomas ADDRESS 3104 Auchentoroly Ter.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 25 1949, *to* June 25 1949, *that I last saw the deceased alive on* June 25 1949, *and that death occurred at* 6 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Francis R. Gluck M. D.	3406 St. Paul St	6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	June 27 1949	Greenmount	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	Charles H. Craig & Son Inc	47) 118 W. Mt. Royal Ave.

VS 150

~~75682~~ G75682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75682

BIRTH NO. ~~75682~~

1. NAME OF DECEASED (Type or Print) Alfred Ayres

2. DATE OF DEATH 6/2X/X9

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1144 S Stockton St
c. Length of stay in Baltimore 30 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md 16-01
D. STREET ADDRESS (If rural, give location) 1144 Stockton St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	July 4, 1893	55	11	20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tent maker		Virginia	U.S.

13. FATHER'S NAME George Ayres

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	W.W.I - 1917		Mary Ayres	1144 Stockton St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mo's

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 9, 1949 *to* June 21, 19X9, *that I last saw the deceased alive on* June 21, 19X9, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. William Frey M. D.	1928 Penna Ave	6/23/X9

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) — (State)
Burial	6-27-49	Balto nat cem.	md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	George A. Kelso	1303 Presstman St.

VS 150

131a

G75683

JL 107396

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75683

1. NAME OF DECEASED (Type or Print) Frances Ryan

2. DATE OF DEATH 6-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore 55 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) 23-01
D. STREET ADDRESS (If rural, give location) 910 Peach St. & 9010 Peachtree St.)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Negro	Married	March 4, 1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Harford Co., Md.
12. CITIZEN OF WHAT COUNTRY? U

13. FATHER'S NAME Andrew Washington
14. MOTHER'S MAIDEN NAME Martha Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT B. C. H. Records. ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

(Please write the cause of death clearly and correct age is especially important. Physicians: please write legibly.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Infarction, right — 15 min.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive Arteriosclerotic Cardiovascular Disease — 2 yrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [Yes] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 7, 1947, *to* June 24, 1949, *that I last saw the deceased alive on* June 24, 1949, *and that death occurred at* 5.55A m., *from the causes and on the date stated above.*

23A. SIGNATURE C. F. Rogers M. D.
23B. ADDRESS 4940 Eastern Ave.
23C. DATE SIGNED 6-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/29/49	Mt Auburn	Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Geo. G. Kelson 1303 Pressman St.

VS 150

937

75684 G75684

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RODERICK EVANS

2. DATE OF DEATH 6/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore 25 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN Balto. #30 (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 905 Leadenhall 23-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	WIDOWED	Apr. 27, 1905	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Panama Canal Zone
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME George Evans
14. MOTHER'S MAIDEN NAME Inez Lingala
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Monica Evans ADDRESS 17 W. Henrietta St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO
(B) Congestive Heart Failure — 4 days
ANTECEDENT, CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/21 1949 *to* 6/25, 1949 *that I last saw the deceased alive on* 6/25, 19 49 *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE Robert E. Ensor M. D.
23B. ADDRESS Mercy Hospital
23C. DATE SIGNED 6/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/30/49
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Lot 0
24D. LOCATION (City, town, or county) Balto. City (State)

DATE RECEIVED BY LOCAL REGISTRAR JUN 27 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR L. L. Brown & Son ADDRESS 108 W Montgomery St

VS 150

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

#3685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 9 2 5 8 G75685 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT SMITH, JR. N-991.

2. DATE OF DEATH June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Embankment near cherry Hill Rd. south of Waterview Avenue

C. Length of stay in Baltimore Yrs.6 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2700 Berea Road 25-32

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	Child	June 6-1942	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Kimball west Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Smith, Sr.

14. MOTHER'S MAIDEN NAME Beatrice Austin 2700 Berea Rd.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Beatrice Smith ADDRESS 2700 Berea Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Asphyxiation	
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) sand hill

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Waterview Avenue Embankment near Cherry Hill Rd. south of

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) June 22, 1949 7p.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? 25-32 Cave-in of clay embankment 25' high

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED June 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6/27/1949

24C. NAME OF CEMETERY OR CREMATORY Mt Calvery Cem.

24D. LOCATION (City, town, or county) (State) Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 27 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Elroy O. Wilson ADDRESS 1000 Brantly Ave

VS 151

182B

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75686 ✓ E975.8 G75686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO B.C.H.-31732 Registered No.

1. NAME OF DECEASED (Type or Print) AL SMITH — N-991

2. DATE OF DEATH June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Embankment near Cherry Hill Rd. south of Waterview Ave.

C. Length of stay in Baltimore All Life Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
2700 Berea Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
male	colored	Child	Sept. I. 1945	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child		Balto. Md.	U.S.A.

13. FATHER'S NAME
Robert Smith

14. MOTHER'S MAIDEN NAME
Beatrice Austin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Beatrice Smith	2700 Berea Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	sand hill	Waterview Ave. Embankment near Cherry Hill Rd. south of

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
June 22, 1949 7p. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Cave-in of clay embankment 25' high 25132

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR	23C. DATE SIGNED
Emil L. Kruger M.D.		June 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/27/1949	Mt. Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	Elroy O. Wilson	1000 Brantly Ave.

VS 151

182 B

Write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G75687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Exh. 7

Registered No. G75687

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ester M. Linsey N-813-7

2. DATE OF DEATH: June 23, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore: 12 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2123 Clifton Ave. 1v-04

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Sep.
8. DATE OF BIRTH: May 17-1908
9. AGE (In years last birthday): 41 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rockhill SC
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unkown
14. MOTHER'S MAIDEN NAME: Bertha Brownn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Grace Brown ADDRESS: I709 Franklin St.

MEDICAL CERTIFICATION

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Crushed Skull
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Gilmor and Edmondson Ave. 19/1
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 23, 1949 2 P. m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Pedestrian struck by bus

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: June 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/27/1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Zion Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: I000 Brantly Ave.

VS 151

170c

G75688

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75688

1. NAME OF DECEASED (Type or Print) CARLOTTA GRIMES (KILIAH GRIMES)

2. DATE OF DEATH 6-24-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE BALTIMORE B. COUNTY MARYLAND
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 17.
D. STREET ADDRESS (If rural, give location) 1124 MOSHER ST 16 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C		8-14-1933	15	10	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME JACK GRIMES
14. MOTHER'S MAIDEN NAME SALOME ROSS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT SALOME GRIMES ADDRESS 1124 MOSHER ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Hepatic Necrosis
DUE TO
(B) Infectious Hepatitis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
22 wks pregnancy 2 Spontaneous Abortion

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-28 1949, *to* 6-24 1949, *that I last saw the deceased alive on* 6-24 1949, *and that death occurred at* 1st A m., *from the causes and on the date stated above.*

23A. SIGNATURE Chris R Mansinger Jr M.D.
23B. ADDRESS Community Hosp.
23C. DATE SIGNED 6-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 6-27-49.
24C. NAME OF CEMETERY OR CREMATORY MT. ARBUTUS PK.
24D. LOCATION (City, town, or county) (State) BALTIMORE CO. MD.

DATE RECEIVED BY LOCAL REGISTRAR JUN 27 1949
REGISTRAR'S SIGNATURE Curtis Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Wm. A. JACKSON, 916 PENNA. AVE

Vs 150

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

125a

G75689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

173

G75689

BIRTH NO. 887 — Registered No.

1. NAME OF DECEASED (Type or Print): Elsie Mae Vennie

2. DATE OF DEATH: June-25-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2514 Huron Str

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) A. STATE Md. COUNTY Baltimore 2514 Huron Str.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25 33

c. Length of stay in Baltimore 10 years. (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 2514 Huron Street.

5. SEX: Fem. | 6. COLOR OR RACE: col. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: March-29-1917 | 9. AGE (In years last birthday): 32 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Greenville Cy - Virginia | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Neal White | 14. MOTHER'S MAIDEN NAME: Queen Victoria Harrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Rassie White | ADDRESS: 2514 Huron Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the uterus. — INTERVAL BETWEEN ONSET AND DEATH: not known

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December 1948 *to* June-25 1949, *that I last saw the deceased alive on* June-20 1949 *and that death occurred at* 2.45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wetherly H. Sommerfeldt M. D. | 23B. ADDRESS: 2708 Hollins Ferry Road | 23C. DATE SIGNED: 6/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 6-28-49 | 24C. NAME OF CEMETERY OR CREMATORY: MT. AUBURN | 24D. LOCATION (City, town, or county) (State): BALTIMORE. MD.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 27 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: WM. A. JACKSON. | ADDRESS: 916 PENNA. AVE.

93 150

48 B

G75690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 r 1

G75690

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Katherine Valentine

2. DATE OF DEATH: 6/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General German Aged Home
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28 04
D. STREET ADDRESS (If rural, give location): 22 S. Athol Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	W.	Widow	July 19 1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Geo. W. Wallrab	Dorothea Gruner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Wm. J. Geo. Wallrab	22 S. Athol Ave

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cardiac Thrombosis	3 days.
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 22/49, 19__, *to* June 25/49, *that I last saw the deceased alive on* June 24/49, *and that death occurred at* 11.50 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Wards Church M. D.	930 Stanwyck	June 27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/29/49	Loudon Pk.	3801 Frederick, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	[illegible] M.D.	Harry H. Weitzel	4101 Edmondson Ave

VS 150

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G75691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75691

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William T. Owens

2. DATE OF DEATH June 23 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1009 Russell St.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1009 Russell St. 21-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	Dec. 4, 1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Musician		Baltimore, Md.	

13. FATHER'S NAME: Thomas Owens

14. MOTHER'S MAIDEN NAME: Katherine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Ella Owens	1009 Russell St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute Cardiac Failure	1 da
	DUE TO (B) Generalized Arteriosclerotic	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO Cardiovascular Disease	yrs
	(C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/10, 1949, *to* 6-23, 1949 *that I last saw the deceased alive on* 6/23, 1949 *and that death occurred at* 4:55 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph H Faulkner M. D.	675 Washington Blvd	6/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 27 '49	Loudon Park	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	Harry N Wisher	4101 Edmondson Ave

93)

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G75692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 3 4

G75692

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Laura Hinkins

2. DATE OF DEATH: June 27,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2101 W. Cold Spr. La.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cold Spring Convalescent Home

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1914 E.Lanvale St. 8 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	W	Jan.21,1874	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Manitowoc Wis.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: August Grosstueck

14. MOTHER'S MAIDEN NAME: Katherine Kennedy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS: Mrs.John Marcin 1914 E.Lanvale St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5yrs

DUE TO

(B) GENERALIZED ARTERIOSCLEROSIS — 10yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* MARCH 10, 1949, *to* JUNE 27, 1949, *that I last saw the deceased alive on* 6/26, 1949, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Norman R. Kleiman M. D. | 23B. ADDRESS: 3903 Edmondson Ave. | 23C. DATE SIGNED: 6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 28,1949	Moreland Mem.	Taylor Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 27 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: ADDRESS: Clarence F.Hoffmann 1639 Broadway.

VS 150

97

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G75693

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

33 Registered No. G75693

1. NAME OF DECEASED (Type or Print): GERTRUDE BARBARA NORRIS

2. DATE OF DEATH: JUNE 24 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2918 ST. PAUL ST.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 6 Oyears. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 301 Tryon Park Drive 1207

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: October 30 1881
9. AGE (In years last birthday): 67
If under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Chicago Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Raymond Piquet

14. MOTHER'S MAIDEN NAME: Minnie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Winnie A. Spellman ADDRESS: 2909 St. Paul St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

(B) HYPERTENSION, ESSENTIAL — 20 years

DUE TO

(C) ARTERIOSCLEROSIS, GENERALIZED

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from NOVEMBER 1948 to JUNE 1949, that I last saw the deceased alive on JUNE 24 1949 and that death occurred at 3:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Peter F. Roberts M. D.
23B. ADDRESS: 420 Sheldon Avenue
23C. DATE SIGNED: June 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-27-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Pk Cem
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm J. Fickus & Son
ADDRESS: Balto. Md.

VS 150

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G75694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75694

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES E. CUMMINGS

2. DATE OF DEATH: 6/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2309 Homewood Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2309 Homewood Avenue 9-68

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 1859
9. AGE (In years last birthday): 90 | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Bookbinder

11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: (?)
14. MOTHER'S MAIDEN NAME: (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -

17. INFORMANT: Mrs. Margaret Kleff 2309 Homewood Avenue

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician: please write correct age is especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atherosclerotic Cardio-Vascular — 10 yrs
DUE TO Renal Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: -
19B. MAJOR FINDINGS OF OPERATION: -
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): -
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): -
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: -
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-18, 1949 *to* 6-23, 1949 *that I last saw the deceased alive on* 6-23, 1949 *and that death occurred at* 9:40 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: P. D. Flynn M.D. M. D.
23B. ADDRESS: 11 E. Chase St.
23C. DATE SIGNED: 6-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/27/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): City

DATE RECEIVED BY LOCAL REGISTRAR: JUN 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WIEDEFELD & SON
ADDRESS: GREENMOUNT AVE & 22ND

VS 150

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G75695

BIRTH NO. BC-49-13298

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75695

1. NAME OF DECEASED (Type or Print): BABY GIRL ALEXANDER

2. DATE OF DEATH: 24 June 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL INC.

c. Length of stay in Baltimore: Yrs. 2 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto, 26-10
D. STREET ADDRESS (If rural, give location): 3255 Boulding St Balto 24

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): (SINGLE)
8. DATE OF BIRTH: 22 June 1949
9. AGE (In years last birthday): — | If Under 1 Year: Months —, Days 2 | If Under 24 Hours: Hours —, Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto-Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM ALEXANDER
14. MOTHER'S MAIDEN NAME: Mary Hallman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S ADDRESS: Hospital Records, Mercy Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Atelectasis — 6 hrs

DUE TO

(C) Respiratory Failure — 6 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 22 June, 1949 to 24 June 1949 *that I last saw the deceased alive on* 24 June 1949, *and that death occurred at* 11:15 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: T. M. Bacon Jr. M. D.
23B. ADDRESS: Mercy Hospital Balto 24
23C. DATE SIGNED: 24 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify): B
24B. DATE: 6-27-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): City

DATE RECEIVED BY LOCAL REGISTRAR: JUN 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WIEDEFELD & SON
ADDRESS: GREENMOUNT & LYND

VS 150

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Please write the cause of death clearly and correct age is especially important. Physician:

G75696 BAUHAUS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75696

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Bauhaus

2. DATE OF DEATH 6/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 803 McAleer Ct.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) 803 McAleer Ct 10-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	S.		81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY ✓

11. BIRTHPLACE (State or foreign country).

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Anthony Bauhaus

14. MOTHER'S MAIDEN NAME Christina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ✓ (If yes, give war or dates of service) ✓

16. SOCIAL SECURITY NO. ✓

17. INFORMANT ADDRESS Court
Bauhaus 803 McAleer

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C-V disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE C. L. Fabrizio M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 28/49	Holy Redeemer	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 27 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Rita Weidefeld ADDRESS 900 E. Biddle

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G75697

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 9.14.3 G75697

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) KENNETH ROBERTS N-922

2. DATE OF DEATH JUNE 24 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTIMORE GEN. HOSP.
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2243 PENROSE AVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	SINGLE	JAN. 9 1936	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
STUDENT		Baltimore	

13. FATHER'S NAME: John P. Roberts

14. MOTHER'S MAIDEN NAME: Alma Carnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	Mrs John P. Roberts	2243 Penrose ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) RESPIRATORY ARREST
DUE TO
(B) 40 BURNS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
William J. McClafferty M.D.
for Chester J. Lubinski M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
accident	industrial place	2237 Edmondson Avenue 20/2

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21F. HOW DID INJURY OCCUR?
June 24, 1949 1.25 P.m.		Contact with high tension wire

22. *I hereby certify that I attended the deceased from* 6/24/49 *to* 6/24/49 *that I last saw the deceased alive on* 6/24/49 *and that death occurred at* 9:40 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leonard A Golombek M. D.	West Balto Gen Hosp	6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-28-49	Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Municipal Archives, M.D.	Brazel Farley Fulton & Fyffe	

VS 150

193

Please write the cause of death clearly and legibly. Physician: please write the exact age if especially important.

G75698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

G75698 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frank C. Thornton

2. DATE OF DEATH June 26 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3806 Milford Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28-01

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 3806 Milford Ave

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH July 20 1874 | 9. AGE (In years last birthday) 74 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter | 10b. KIND OF BUSINESS OR INDUSTRY Market | 11. BIRTHPLACE (State or foreign country) Va | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Benjamin W. Thornton | 14. MOTHER'S MAIDEN NAME Catherine E Cooke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — | INTERVAL BETWEEN ONSET AND DEATH 24 hrs

DUE TO

(B) Generalized Arteriosclerosis | yrs

DUE TO

(C) Mentally Depressed — | 6 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* —— *to* June 26 1949, *that I last saw the deceased alive on* June 25 1949, *and that death occurred at* 2 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE Dr Thos J Abbott M. D. | 23B. ADDRESS 4509 Liberty Heights Ave | 23C. DATE SIGNED 6-25

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE June 28, 1949 | 24C. NAME OF CEMETERY OR CREMATORY Western Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 27 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | FUNERAL DIRECTOR Willis Lamoreau | ADDRESS 4510 Liberty Heights Ave.

VS 150

83a

Please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and

G75699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75699

BIRTH NO. 11

1. NAME OF DECEASED (Type or Print) Mr. Samuel D Ring

2. DATE OF DEATH 6/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Relay
D. STREET ADDRESS (If rural, give location) Sulphur Spring Rd & Rolling Road

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan. 21, 1873
9. AGE (In years last birthday) 76 yrs
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Road Superintendent
10B. KIND OF BUSINESS OR INDUSTRY Baltimore County
11. BIRTHPLACE (State or foreign country) Baltimore County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME George M. Ring
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. No
17. INFORMANT George W. Ring, 1825 Selma Ave. ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Coronary — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO
(B) Heart disease — 2 days
DUE TO
(C) pulmonary congestion.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/24, 1949, to 6/26, 1949, that I last saw the deceased alive on 6/26, 1949, and that death occurred at 3:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE Wm F. Benson M. D.
23B. ADDRESS Un. Hosp.
23C. DATE SIGNED 6/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 29, 1949
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 27 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
FUNERAL DIRECTOR Wills Amoroso
ADDRESS 4510 Liberty Heights Ave.

VS 150

94a

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G75700

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75700

1. NAME OF DECEASED (Type or Print) Mr. John Thomas Worthington

2. DATE OF DEATH 6/25/49

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. Length of stay in Baltimore 2 weeks (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Ellicott city Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ellicott city
D. STREET ADDRESS (If rural, give location) Howard Co. Maryland

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	Wh	Married	Jan 13, 1896	53	5	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Agent
10B. KIND OF BUSINESS OR INDUSTRY Real Estate
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Mr. John Thomas Worthington Sr.
14. MOTHER'S MAIDEN NAME Ida Grooms

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) 1st world war
16. SOCIAL SECURITY NO. 579-07-9111
17. INFORMANT Mrs. Neville Worthington Jr. ADDRESS Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Myocardial infarction	1½ hours
DUE TO (B)	Precoris Myocardial Infarction	2 weeks
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Coronary sclerosis	

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/11, 1949 *to* 6/25, 1949 *that I last saw the deceased alive on* 6/25, 1949 *and that death occurred at* 10:20 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE Parker Scott Jr. M. D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 6/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 28, 1949.
24C. NAME OF CEMETERY OR CREMATORY St. John's Cemetery
24D. LOCATION (City, town, or County) (State) Olney, Montgomery Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 29 1949
REGISTRAR'S SIGNATURE Thurlington Williams, M.D.
25. FUNERAL DIRECTOR Easton Sons ADDRESS Ellicott City, Md.

VS 150

94a

Please write the cause of death clearly and correct age is especially important. Physician: please write the

G75701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75701

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HERBERT JEROME O'CONNOR

2. DATE OF DEATH June 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 146 S. Culver Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
male	white	single	Feb. 18, 1915	34	4	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY: Rubber Plant

11. BIRTHPLACE (State or foreign country): Howard Co., Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph O'Connor

14. MOTHER'S MAIDEN NAME: Mary Hajek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-3320

17. INFORMANT: Mrs. George Haker — ADDRESS: 146 S Culver St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Benzol poisoning	
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): factory

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Crown Cork & Seal Co. 4300 Eastern Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 24, 1949 11 p. m.

21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY Ooccur? Overcome by Benzol fumes while painting inside of tank

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED June 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/28/49	St. Marys Cemetery	Ilchester, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 27 1949

REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.

25. FUNERAL DIRECTOR: Easton Sons — ADDRESS: Catonsville, Md

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1794

75702

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75702

1. NAME OF DECEASED (Type or Print) Annie Lemmon or (Lemon)

2. DATE OF DEATH June 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 812 E. 22nd St.

c. Length of stay in Baltimore 65 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 812 E. 22nd St. 9-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Widow	July 12, 1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	at home	Ireland	U.S.A.

13. FATHER'S NAME Wm. Joyce

14. MOTHER'S MAIDEN NAME Nora ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		M. A. Lemmon	812 E. 22nd St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Myocardial Insufficiency	12 hours
DUE TO (B)	Chr. Myocarditis	1 year
DUE TO (C)	Generalized Arteriosclerosis	8 yrs.
	Chronic Interstitial Nephritis	10 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 6- ____, 19 49 *that I last saw the deceased alive on* 6- ____, 1949, *and that death occurred at* 4:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas J. Mate M. D.	3809 Fortunate Ave.	6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	6-28-49	Cathedral	Baltimore City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	C. Vernon Lemmon	4611 Pk. HGTS. Ave.

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

937

G75703

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45' 1

G75703

Registered No.

1. NAME OF DECEASED (Type or Print) Annie Carpenter

2. DATE OF DEATH 6-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Home

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1032 N Fulton Ave. 16 04

5. SEX Female | 6. COLOR OR RACE Col. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH April 11, 1860 | 9. AGE (In years last birthday) 89 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Annapolis Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Nettie Robinson ADDRESS 1032 N Fulton Ave

MEDICAL CERTIFICATION

(Physician: please write the cause of death clearly and legibly. Exact age is especially important.)

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility - Senile Dementia — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Arteriosclerosis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 21, 19 49, *to* June 24, 19 49, *that I last saw the deceased alive on* June 23, 19 49, *and that death occurred at* 4 4 *m., from the causes and on the date stated above.*

23A. SIGNATURE Melvin N. Borden M. D. | 23B. ADDRESS 2030 W. Fayette St | 23C. DATE SIGNED 6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE June 27, 1949 | 24C. NAME OF CEMETERY OR CREMATORY Mt Auburn | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 27 1949 | REGISTRAR'S SIGNATURE Turlington Williams, M.D. | 25. FUNERAL DIRECTOR Mrs Katie R Williams | ADDRESS 3227 W Lafayette Ave

97

G75704 ✓ G75704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1949

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Concetta DE. Diaugenio**

2. DATE OF DEATH **June 25 1949**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **2211 Huntington Ave**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **2211 Huntington Ave** 12-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	**White**	**Married**	**April 4 1904**	**45**	**2**	**21**		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Doffer	**Cotton Mill**	**Acqua Formosa Italy**	

13. FATHER'S NAME **Vincenzo Di Martini**

14. MOTHER'S MAIDEN NAME **Carmela Dotore**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		215-07-6637	**John Diaugenio**	**2211 Huntington Ave**

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write in especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Carcinoma**

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 19**44**, to **June 25**, 19**49**, *that I last saw the deceased alive on* **June 25** 1949, *and that death occurred at* **4:50** A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
O. B. Franklin M. D.	**1123 St Paul St**	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**June 28 1949**	**[illegible] Memorial Cemetery**	**4300 Old Frederick Rd. Balt. Md.**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR	FUNERAL DIRECTOR	ADDRESS
JUN 27 1949		**Frank Pelly Sons**	**322 S. High St.**

VS 150

540

G75705 ✓X 60 G75705

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE CHARLES KITCHING

2. DATE OF DEATH: June 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital
Wyman Park Drive & 31st St.

C. Length of stay in Baltimore: 57 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Somerset
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ewell
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	6/28/81	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mate	Seafarer	Va.	USA

13. FATHER'S NAME: Seymour Kitching

14. MOTHER'S MAIDEN NAME: Martha ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Unknown	Unknown	Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION — Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		Interval between onset and death
(A)	Cerebral arteriosclerosis	3 mos.
DUE TO		
(B)	Diabetes mellitus	5 years
DUE TO		
(C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Apr. 30, 1949, *to* June 26, 1949 *that I last saw the deceased alive on* June 26, 1949, *and that death occurred at* 11:35 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles D. Churchill M. D.	US Marine Hospital, Balto, Md.	6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/30/49	Ewell Cemetery	Crisfield Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Williams, M.D.	Bradshaw	Crisfield Md.

VS 150

61

G75706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G75706

1. NAME OF DECEASED (Type or Print) OCASIO, Felicita

2. DATE OF DEATH June 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U. S. Marine Hosptal

c. Length of stay in Baltimore unk Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 725 Patapsco Ave., 25-04

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Mar 9, 1870
9. AGE (In years last birthday) 79 | If under 1 year: Months, Days | If under 1 day: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10B. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) P. R.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Silverio Ocasio
14. MOTHER'S MAIDEN NAME Maria Morales

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unk
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. unk

17. INFORMANT Records ADDRESS US Marine Hospital

MEDICAL CERTIFICATION

Write the cause of death clearly and correct age is especially important. Physician: please write legibly.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of lung. (primary suspected) — INTERVAL BETWEEN ONSET AND DEATH: unk
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of vulva (apparently cured) — unk

19A. DATE OF OPERATION none
19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 22, 1949 *to* June 25, 1949, *that I last saw the deceased alive on* June 25, 1949, *and that death occurred at* 10:15p m., *from the causes and on the date stated above.*

23A. SIGNATURE J. L. Fuis Jr. M.D. D.O.D. M. D.
23B. ADDRESS U.S. Marine Hospital
23C. DATE SIGNED 6/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) B
24B. DATE 6/28/49
24C. NAME OF CEMETERY OR CREMATORY Glen Haven
24D. LOCATION (City, town, or county) (State) Glen Burnie

DATE RECEIVED BY LOCAL REGISTRAR JUN 27 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR James L McCauley
ADDRESS 130 East Fort Ave

VS 150

47D

G75707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75707

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alfred Samm

2. DATE OF DEATH 6-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
West Baltimore General

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Carvel Beach
D. STREET ADDRESS (If rural, give location) Carvel Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	3/3/1907	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Furniture Finisher	Hub Furniture Co.	Baltimore	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Louis H. Samm	Lenora Wilde

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Family - Same	

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Lymphosarcoma - type undetermined	4 mo.
	DUE TO (B) involvement of lung, liver, pancreas	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) Rt testis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-18 *19*49 *to* 6-23 *19*49 *that I last saw the deceased alive on* June 25 *19*49 *and that death occurred at* 1:53 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leonard Fuchs M.D.	1 West Balt Gen'l Hosp	6-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	6/29/49	Cedar Hill	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 27 1949	Huntington Holloway, M.D.	Logan L. McCurdy	130 E. Fort Ave.

VS 150

55E

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G75708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 334

Registered No. G75708

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY PARKER RAYNOLDS

2. DATE OF DEATH 6-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1824 N. BROADWAY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE BALTIMORE — MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1824 N. BROADWAY 8-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F.	W.	SINGLE	Oct. 9-1859	89				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) BALTIMORE.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Benjamin Raynolds ?

14. MOTHER'S MAIDEN NAME Christiana Miller - ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Jas Edwin Cook ADDRESS 109 Enfield Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis-cerebral + generalized — INTERVAL BETWEEN ONSET AND DEATH 5 yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 19, 1943, to June 25, 1949, *that I last saw the deceased alive on* June 15, 1949, *and that death occurred at* 7:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Francis W Gluck M. D.

23B. ADDRESS 3406 St Paul St

23C. DATE SIGNED 6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6-28-49

24C. NAME OF CEMETERY OR CREMATORY BALTIMORE —

24D. LOCATION (City, town, or county) (State) BALTIMORE - Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR William Cook-Inc. ADDRESS 1717 St Paul St

VS 150

97

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75709

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59 Registered No. G75709

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John B. Pullifrone

2. DATE OF DEATH 6/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp.

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01
D. STREET ADDRESS (If rural, give location) 1036 Warden St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	Feb 9, 1907	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
BARBER	OWN	Penna.	USA

13. FATHER'S NAME Rocco Pullifrone

14. MOTHER'S MAIDEN NAME Elizabeth Calagh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N		NONE	Joshua R Pullifrone	1036 Warden St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia

ANTECEDENT CAUSES
DUE TO
(B) Chronic Glomerular nephritis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/21, 1949 *to* 6/25, 1949, *that I last saw the deceased alive on* 6/25 1949, *and that death occurred at* 4:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph L. Aponte M. D.	Mercy Hospital	6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/28/49	Holy Redeemer	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	Tillman & Doe	1214 E Pratt St

VS 150

1316

Please write the cause of death clearly and legibly. Physician: please be especially careful that age is entered.

G75710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 7 r 3 1 / G75710

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CATHERINE McCALL

2. DATE OF DEATH 6-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3802 LEO St.

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO. CURTIS BAY
D. STREET ADDRESS (If rural, give location) 3802 LEO St. 25-06

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 4-26-1888
9. AGE (In years last birthday) 61 — If under 1 year: Months, Days; If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Penn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JAMES SPENCER

14. MOTHER'S MAIDEN NAME CATHERINE COWAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
16. (If yes, give war or dates of service) —
SOCIAL SECURITY NO. ?

17. INFORMANT ETHEL SELIG
ADDRESS SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic interstitial nephritis — INTERVAL BETWEEN ONSET AND DEATH: 1 year about
DUE TO
(B) Chronic myocarditis
DUE TO
(C) Chronic arthritis (deformans) — 6 years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 17, 1948, *to* June 24, 1949, *that I last saw the deceased alive on* June 24, 1949, *and that death occurred at* 6:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Harry Deibel M. D.
23B. ADDRESS 1326 Hanover St
23C. DATE SIGNED 6/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 6/28/49
24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS
24D. LOCATION (City, town, or county) [redacted] A. H. Co. (State) MD
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR WILLY & ZEILER 403 S. WOLFE

VS 150

1310

G75711

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75711

1. NAME OF DECEASED (Type or Print) William W Walstrum

2. DATE OF DEATH 6-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 638 W.Fayette Street

c. Length of stay in Baltimore — Yrs. Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — COUNTY City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 638 W.Fayette Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Jan.1st.,1876	73	5	25	XXX	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Helper on Truck	Brewery	Baltimore,Maryland	U.S.A.

13. FATHER'S NAME
William H.Walstrom

14. MOTHER'S MAIDEN NAME
Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	None	212-12-0651

17. INFORMANT — ADDRESS
Mrs.Elizabeth M.Walstrum, 638 W.Fayette Street

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia - chronic N.D. Nephritis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Ruth M.D.		26 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	6-29-49	Baltimore Cemetery	E.North Avenue,Balto,Md.

DATE RECEIVED LOCAL REGISTRATION JUN 27 1949

REGISTRAR'S SIGNATURE Thurlington for Baltimore, Md.

25. FUNERAL DIRECTOR — ADDRESS
George J.Ruth,Inc. — 1735 Harford Avenue

VS 151

939

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G75712

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75712

1. NAME OF DECEASED (Type or Print): Mary E.Street

2. DATE OF DEATH: June 26th.1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1642 Holbrook Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1642 Holbrook Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	If under 1 year: Days	If under 1 day: Hours	If under 1 day: Min.
Female	White	Widowed	Oct.4th.,1860	88	8	22	XXX	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore,Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Alexander Slayman	Sarah E.Wright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	None	Mr. James G.Waltermyer	White Hall,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1hr.

DUE TO

(B) Arteriosclerotic Heart Disease — 10 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Senile

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: General Debilitation — 1 yr.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* April 1, 1949, *to* June 26, 1949, *that I last saw the deceased alive on* June 26, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert B. Tunney M. D.	920 St Paul St	6-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6-29-49	Baltimore Cemetery	E.North Avenue,Balto:Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	George J.Ruth,Inc.	1735 Harford Avenue

VS 150

931

Write the cause of death clearly and correct age is especially important. Physician: please write the

G75713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75713

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES TWILLEY

2. DATE OF DEATH June 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1048 North Broadway 7-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white			70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arterio-Sclerotic C. V. Disease	
ANTECEDENT CAUSES	DUE TO (B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from* Autopsy, Inspection or Inquiry *the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED June 2, 1949
Earl L. Rogers			

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL JUN 27 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	[illegible] Board of Health	

VS 151

939

575714

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 575714

1. NAME OF DECEASED (Type or Print): Baby Girl Hill

2. DATE OF DEATH: June 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

C. Length of stay in Baltimore: Yrs. / Mos. / Days: 1

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Victory Villa Gardens.
D. STREET ADDRESS (If rural, give location): 10 Maxwell Road.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W.	S.	June 2, 1949			9 / 13

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant		Victory Villa Gardens	U.S.

13. FATHER'S NAME: Hanford Hill

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no.				

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity c atelectasis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 9 hrs 13 m / 5 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 2, 1949, *to* June 3, 1949, *that I last saw the deceased alive on* June 3, 1949, *and that death occurred at* 7:10 AM m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marguerite Louise Candler, M.D. M. D.	Md. General Hospital	6-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	JUN 8 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

Please write the cause of death clearly and legibly. Physician's signature is especially important. Please correct age if necessary.

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G75715

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 49-11986 **CERTIFICATE OF DEATH** 759 Registered No. G75715

1. NAME OF DECEASED (Type or Print): Johnson, Baby

2. DATE OF DEATH: 6-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

C. Length of stay in Baltimore: 18 hrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Point 201 Old North Point Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	W	Single	6-2-49	18 hrs.		18

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant	—	Balto. Md.	USA

13. FATHER'S NAME: George Bonkert

14. MOTHER'S MAIDEN NAME: Mary Alice Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		none	Mother	Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs.

DUE TO

(B) Aspiration Pneumonia? — 3 hrs.

DUE TO

(C) Tracheo-Esophageal fistula — 18 hrs

ANTECEDENT CAUSES

I DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from June 2 1949 to June 3, 1949 that I last saw the deceased alive on June 2, 1949 and that death occurred at 8 00 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	University Hosp.	6-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	JUN 8 1949

DATE RECEIVED BY: JUN 28 1949

REGISTRAR'S SIGNATURE: [signature] Washington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS

Commissioner of Health

VS 150

157E

Please write the cause of death clearly and correct age is especially important. Physician:

G75716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-11638

Registered No. G75716

1. NAME OF DECEASED (Type or Print): Baby Boy Beyer

2. DATE OF DEATH: June 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1435 Catherine St 20-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White		June 3, 1949				16	24

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Adam Thomas Beyer

14. MOTHER'S MAIDEN NAME: Albertha Roslee Stockom

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother ADDRESS: Same

MEDICAL CERTIFICATION

Direct age is especially important. Physician: please write the cause of death clearly and legibly.

16. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Premature expulsion of placenta Atelectasis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prematurity

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/4/49	Atelectasis	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/3, 1949, *to* 6/4, 1949, *that I last saw the deceased alive on* 6/4, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. D. Cayler Jr. M. D.	West Baltimore Dsn	6/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	JUN 8 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

160C

G757.17

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

99 8 G757.17
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs Sarah Brunion

2. DATE OF DEATH 6-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai

C. Length of stay in Baltimore 40 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-16
D. STREET ADDRESS (If rural, give location) 3408 Dupont Ave

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH
9. AGE (In years last birthday) 60 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lith
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Not Known
14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT David Brown - 3408 Dupont Ave ADDRESS

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write in detail. It is especially important that the exact age is entered.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized carcinomatosis
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-23, 1949, *to* 6-28, 1949, *that I last saw the deceased alive on* 6-28, 1949, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Jerome Gaber M. D.
23B. ADDRESS Sinai Hosp
23C. DATE SIGNED 6-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6-28-49
24C. NAME OF CEMETERY OR CREMATORY Rosedale
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eutaw Pl

VS 150

55E

G75718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75718

Registered No.

DEATH NO.

1. NAME OF DECEASED (Type or Print) Tobie Sandy Or Sandigursky

2. DATE OF DEATH June 26 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2426 Eutaw Place

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 45 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) 2435 Eutaw Place 13-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	June 15,1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	None	Russia	

13. FATHER'S NAME: Joseph Schockett

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Nathan B. Scherr ADDRESS 2426 Eutaw Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Diabetes Mellitus — 2yr.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1948 *to* June 26, 1949, *that I last saw the deceased alive on* June 26, 1949 *and that death occurred at* 9.45P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph S. Blum M. D.	1115 N. Calvert St	6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 28,1949	Hebrew Mt Carmel Cem	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	Sol Levinson & Bros	1124 W North Ave

VS 150

61

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75719 Correct form ✓ 162 5 G75719

BIRTH NO. B.C.49-12728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) HERMAN ELLSWORTH Hartman

2. DATE OF DEATH June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
West Balto General Hosp

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 23
D. STREET ADDRESS (If rural, give location) 401 N. Fulton Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		June 15, 1949	19-01		3 / 23

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	

13. FATHER'S NAME
Herman Ellsworth Hartman

14. MOTHER'S MAIDEN NAME
Georgetta Frances Lang

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mother	401 Fulton Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral Atelectasis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 15, 1949 *to* June 15, 1949 *that I last saw the deceased alive on* June 15, 1949 *and that death occurred at* 5:00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Daniel Louis Silverstein M. D.	West Balto. Gen. Hosp.	6/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		JOHN HOPKINS MEDICAL SCHOOL	JUN 17 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	COMMISSIONER OF HEALTH	

VS 150

159

G75720

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1544 G75720

Registered No.

BIRTH NO. BC 49 12608

1. NAME OF DECEASED (Type or Print): Baby Girl Wetzel

2. DATE OF DEATH: 6/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hosp.

C. Length of stay in Baltimore: Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md —
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21
D. STREET ADDRESS (If rural, give location): 1013 Kidgely St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	—	6/14/49			18

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Maryland	USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Martha Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	—	—

17. INFORMANT: Martha Wetzel — ADDRESS —

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Congenital Lues.	
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) Cleft palate, Low Set Ears	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
—	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 6/14, 1949 *to* 6/15, 1949 *that I last saw the deceased alive on* 6/14, 1949 *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. M. Chrisfield Jr. M. D.	Franklin Sq. Hosp	6/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
—	—	UNIVERSITY MEDICAL SCHOOL	JUN 17 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	[redacted] DIRECTOR OF HEALTH	ADDRESS
JUN 28 1949	Huntington Williams, M.D.		

VS 150

157E

Please write the cause of death clearly and correct age is especially important. Physician: please write plainly.

G75721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-12300

Registered No. G75721

1. NAME OF DECEASED (Type or Print): Baby Boy Socktitet

2. DATE OF DEATH: 6/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-0
D. STREET ADDRESS (If rural, give location): 622 Scott Street #30

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	infant	6/14/49				9	43

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
infant	infant	Md.	U.S.

13. FATHER'S NAME: Edward Tindall Socktitet

14. MOTHER'S MAIDEN NAME: Sadie Louise Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
infant	none	Sadie Socktitet	622 Scott St #30 Balto md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Erythroblastosis fetalis
DUE TO
(B) Rh incompatibility ~~reacting titre~~ of ~~antibodies~~
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Rh incompatibility; rising titre of antibodies;

INTERVAL BETWEEN ONSET AND DEATH
~~Erythroblastosis fetalis~~ 4 days
~~Rh incompatibility~~ 4 days
~~rising titre~~
~~of antibodies~~
~~noted intrapartum~~
~~cordocentesis~~

19A. DATE OF OPERATION: On mother for delivery
19B. MAJOR FINDINGS OF OPERATION: ~~modified~~ water extraperitoneal Ces. section

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/14, 1949 *to* 6/14, 1949, *that I last saw the deceased alive on* 6/14, 1949, *and that death occurred at* 12:17 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John R Hawkins M. D.	University Hospital	6/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
City Disposal		UNIVERSITY MEDICAL SCHOOL JUN 24 1949	

DATE RECEIVED BY LOCAL REGISTRAR: JUN 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Commissioner of Health

ADDRESS

VS J50

161a

G757722

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G757722

1. NAME OF DECEASED (Type or Print) FRANCES. BECHLER.

2. DATE OF DEATH June 25-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3726-Old Fredrick Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —
C. Length of stay in Baltimore 80 yrs. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2007
D. STREET ADDRESS (If rural, give location) 3726 Old Frederick Road.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed.	Nov. 18-1865	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife.	Own Home.	Germany.	U.S.A.

13. FATHER'S NAME Unknown.

14. MOTHER'S MAIDEN NAME Unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	No.	None	Joseph Bechler.	203 S. London Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — Interval between onset and death: 1 day
DUE TO
(B) General arteriosclerosis — ?
DUE TO
(C) Diabetes Mellitus — 4 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 1945 *to* 6/25, 1949 *that I last saw the deceased alive on* 6/21, 1949 *and that death occurred at* 6.50 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Samuel Palgrid M. D.	33 W. Fredrick St	6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial.	June 29-49.	New Cathedral Cemetery.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Thurlington for Williams, M.D.	Charles J. Schwalz.	3512 Frederick - Ave.

VS 150

61

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75723

BIRTH NO. B.C. 49-12022

1. NAME OF DECEASED (Type or Print): BABY GIRL BARNES

2. DATE OF DEATH: JUNE 22, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middle River - 20
D. STREET ADDRESS (If rural, give location): 823 Middle River Rd.

5A. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for the Women of Maryland

5B. Length of stay in Baltimore: ~~Year~~ Mos. 8 Days

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 6-14-49
9. AGE (In years last birthday): If Under 1 Year: Months — Days 8; If Under 24 Hours: Hours 3 Min. 55

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Paul George Barnes
14. MOTHER'S MAIDEN NAME: Vivian Marie Donecker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Vivian Barnes ADDRESS: 823 Middle River Rd. Middle River - 20 Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO

ANTECEDENT CAUSES
(B) DUE TO

II
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C) Multiple Congenital Abnormalities — INTERVAL BETWEEN ONSET AND DEATH: 8 days.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 14, 1949, *to* June 22, 1949, *that I last saw the deceased alive on* June 22, 1949, *and that death occurred at* 9:55 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: William H. Spencer, Jr. M. D.
23B. ADDRESS: Hosp. for Women of Md.
23C. DATE SIGNED: June 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): JUN 24 1949

DATE RECEIVED BY LOCAL REGISTRAR: JUN 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 150

157M

G75724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75724

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Richard Patton

2. DATE OF DEATH June 26 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1125 Gorsuch Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 1125 Gorsuch Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	Feb. 20th, 1870	79	4	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Cons. Engineer	Harford County, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William H. Patton	Frances Gilbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	Spanish American	220-07-9842	Mrs. W.R. Patton	1125 Gorsuch Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs

DUE TO

(B) Arterio-Sclerotic Cardio-Vascular Disease — 10+ yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1946 *to* June 26 1949 *that I last saw the deceased alive on* June 26, 1949, *and that death occurred at* 8:15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. V.D. Mack M. D.	513 E. 39th St	June 26,

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	6/29/49	William Watters Memorial	Cooptown, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Lassahn Funeral Home — ADDRESS: 7401 Belair Rd.

VS 150

93D

Please write the cause of death clearly and legibly. Physician please write the correct age is especially important.

G75725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

G75725

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Alice Washington

2. DATE OF DEATH June 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 105 N. Chapple St

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto City
D. STREET ADDRESS (If rural, give location) 105 N. Chapple St 6 04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months Days	If under 24 hours: Hours Min.
F	C	Widowed	1896	53 56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	at Home	Va	

13. FATHER'S NAME —

14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Ruth Jackson	105 N. Chapple St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebel Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-sclerosis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1949 *to* June 26, 1949, *that I last saw the deceased alive on* June 26, 1949, *and that death occurred at* 1:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marrs A Dine M. D.	114 Bisquit St	June 28th 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	June 29, 1949	Warrenton Va	Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	George G. Nelson	1303 Presstman St

VS 150

83a

Write the cause of death clearly and legibly. Physician please write the cause of death clearly and legibly. Physician please write the cause of death clearly and legibly. Physician please

G75726 Correct form G75726

BIRTH NO. B.C. 49-12850

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Bourke

2. DATE OF DEATH: June 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 25
D. STREET ADDRESS (If rural, give location): 4011 Third St 75 04

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: June 14, 1949
9. AGE (In years last birthday): If Under 1 Year: Months Days; If Under 24 Hours: Hours 11 Min. 21

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Clay Bourke III
14. MOTHER'S MAIDEN NAME: Betty Stilwell Blake

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother ADDRESS: 4011 Third St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bilateral Atelectasis
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 14, 1949 *to* June 15, 1949 *that I last saw the deceased alive on* June 15, 1949, *and that death occurred at* 5:40 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Daniel Silverstein M. D.
23B. ADDRESS: West Balto Gen. Hosp.
23C. DATE SIGNED: 6/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: JOHNS HOPKINS MEDICAL SCHOOL JUN 17 1949
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JUN 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. F[illegible] DIRECTOR OF HEALTH
ADDRESS:

VS 150

159

75727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 31

G75727 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Elizabeth Russell LANAHAN

2. DATE OF DEATH June 26/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5625 Ready Ave.
c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 57-48
D. STREET ADDRESS (If rural, give location) 5625 Ready Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F.	W	Widowed	Feb 9 1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Hamilton Russell
14. MOTHER'S MAIDEN NAME Mary Snyder
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Elizabeth Goodman ADDRESS 5625 Ready Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 2 hrs

DUE TO

(B) Arteriosclerosis — Years

DUE TO Hypertension

(C) Severe Anemia - Due to Carcinoma of Cervix with Pelvic Abscess?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 24, 1949 *to* June 26, 1949, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE E. Bernard Cohen M. D.
23B. ADDRESS Maryland Ave
23C. DATE SIGNED 6-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 29/49
24C. NAME OF CEMETERY OR CREMATORY Green Mount.
24D. LOCATION (City, town, or county) (State) Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Henry Wenkins Sons ADDRESS 4905 York Rd

VS-150

83a

Please write the cause of death clearly and completely. Physician: please write legibly. Every item is important. Physician: please write the cause of death clearly and completely. Every item is important. Physician: please write legibly. Every item is important. Physician: please write the cause of death clearly and completely. Every item is especially important.

CERTIFICATE CORRECTED [redacted]

G75728 jl - 127873 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G75728

BIRTH NO. Liddell

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print) Lemuel Hall

2. DATE OF DEATH 6-26-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 2 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 666 Vine St. 4-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Negro	Married	April 23, 1909	40	3	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Richard Hall

14. MOTHER'S MAIDEN NAME Margaret Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT B. C.H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Far advanced Pulmonary Tuberculosis — 6 mos.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [Yes] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 3-29-49, 19__, *to* June 26, 1949, *that I last saw the deceased alive on* June 26, 1949, *and that death occurred at* 10 am m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. S. Mozeis M. D.	4940 astern Ave.	6-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	6-29-49.	MT. CALVARY	A. A. Co. MARYLAND.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 28 1949	Huntington Williams M.D.	Wm. A. JACKSON, 916 PENNA. AVE

VS 150

13B

G75729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75729

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Dora Johnson Moore

2. DATE OF DEATH June 26, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 620 E 28th St.

c. Length of stay in Baltimore 19 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
d. STREET ADDRESS (If rural, give location) 620 E 28th St. 9-64

5. SEX F.

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Wd.

8. DATE OF BIRTH Oct. 26 1887

9. AGE (In years last birthday) 61 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Middlesex Co Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Allen Carr

14. MOTHER'S MAIDEN NAME Hammer Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Cora Lyle ADDRESS 620 E 28th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis - general — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(B) Carcinoma of Stomach

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar. 12 1949 *to* June 26, 1949, *that I last saw the deceased alive on* June 26 1949, *and that death occurred at* 0 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Wm. LeRoy Berry M. D.

23B. ADDRESS 1420 E Chase

23C. DATE SIGNED 6-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE June 30 49

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem

24D. LOCATION (City, town, or county) (State) A. A. County Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Mrs Cobb & Elliott Dept

ADDRESS 1129 N. Carlton St

VS 150

46B

Please write the cause of death clearly and legibly. Physician please write important. Correct age in especially

G75730

BIRTH NO. G75730

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75730

1. NAME OF DECEASED (Type or Print): Addie Hendricks

2. DATE OF DEATH: June 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Med. Col. 4
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 13 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-09
D. STREET ADDRESS (If rural, give location): 1414 N. Carolina St

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 53 (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: George Kidd
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Shock
DUE TO
(B) Diabetic Acidosis — ? 3d.
DUE TO
(C) Diabetes Mellitus

ANTECEDENT CAUSES

II
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cystitis — ?

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY Ooccur?:

22. *I hereby certify that I attended the deceased from* 6-27- , 1949 to 6-27- , 1949, *that I last saw the deceased alive on* 6-27- , 1949 *and that death occurred at* 10:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE: D. Jackson M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: June 29/49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Brunswick Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Ruth A. Elliott + Dtr. ADDRESS: 1129 N. Carolina St

61

VS 150

CERTIFICATE CORRECTED 6-29-49

75731 F - 129298 Clift

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH E 9 0 3.0 Registered No. G75731

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret (Clift) Clift N-921.0

2. DATE OF DEATH 6-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 12-04

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2203 St. Paul St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	White	Widow	Mar. 1, 1859	90		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Ohio	

13. FATHER'S NAME Frank Saunders

14. MOTHER'S MAIDEN NAME Cynthia (Sinthia) Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		B. C. H. Records,	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

(B) Intertrochanteric fracture of left Femur

DUE TO

(C) Diabetes Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
A. B. Merrill MD
For: Robert B. McFadden, M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ No NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Fractured Hip	at home	2203 St. Paul St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
May 30, 1949 m.	WHILE AT WORK no ☐ NOT WHILE AT WORK	Fell in Bath room (Slipped on floor.)

22. *I hereby certify that I attended the deceased from* May 30, 1949 *to* June 26, 1949, *that I last saw the deceased alive on* June 26, 1949, *and that death occurred at* 11.58PM., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. S. Cozen M. D.	4940 Eastern Ave.	6-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or [illegible]) (State)
Burial	6/29/49	London Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Hunter Williams, M.D. for	Wilbur Cofford	1217 Hollins St

VS 150

To be approved by Medical Examiner.

186a

G75732

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75732
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Ruth Buckner

2. DATE OF DEATH: June 25 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Med. Osl 2
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-03
D. STREET ADDRESS (If rural, give location): 2560 Woodbrooke Ave

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3.22.10
9. AGE (In years last birthday): 39
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Lee
14. MOTHER'S MAIDEN NAME: Mary Alston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Arterio + arteriolar sclerotic Nephritis

DUE TO

(C) and hypertensive cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from June 25 '49 to June 25 1949 that I last saw the deceased alive on June 25 19 49 and that death occurred at 2-25 p. m., from the causes and on the date stated above.

23A. SIGNATURE: David Rubens M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 30 1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore County Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 28 1949
REGISTRAR'S SIGNATURE: Timothy for Williams, M.D.
25. FUNERAL DIRECTOR: Lotte Thos
ADDRESS: 1408 Fish Ed Ave

VS 150

131a

G75733

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75733

Registered No.

1. NAME OF DECEASED (Type or Print): August Klappreth

2. DATE OF DEATH: 6-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto Gen. Hosp

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 27-05
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3021 ORLANDO AVE.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	6-18-1861	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Sheet Metal Const	GERMANY	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		MRS. ANNA M. KLAPPROTH	- Above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia - Left lower lobe — INTERVAL BETWEEN ONSET AND DEATH: 16 days
DUE TO complete right lung

(B) Arteriosclerotic cardiovascular disease
DUE TO

(C)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-23, 1949, *to* 6-27, 1949, *that I last saw the deceased alive on* 6-27, 1949, *and that death occurred at* 3:05 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Katherine V. Kemp M. D.	West Balto. Gen'l Hospital	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	6-30-49	PARKWOOD CEM.	BALTO. CO., MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
6/28/49	Huntington Williams, M.D.	LEONARD J. RUCK.	5305 HARFORD RD.

VS 150

108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

075734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 075734

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Virginia Love Biddle

2. DATE OF DEATH: June 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Providence Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. ?? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1110 Lafayette Ave. 16 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	M	12/22/1920	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Typist		Va.	

13. FATHER'S NAME: Charlie Love

14. MOTHER'S MAIDEN NAME: Gladys Gordon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		?	Mary Parker	709 N. Fremont Av

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured Right Tubal Pregnancy — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Secondary Hemorrhage

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-22, 1949 *to* 6-25, 1949 *that I last saw the deceased alive on* 6-25, 1949 *and that death occurred at* 7:45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. Franklin Phillips M. D.	1543 Pq. Cir.	6/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/28/49	Mt Auburn	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	Geo. G. Kelson	1303 Presstman St.

VS 150

142B

G75735

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

Registered No. G75735

1. NAME OF DECEASED (Type or Print) Levin I. Ross

2. DATE OF DEATH June 24- 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1938 Lauretta Ave

c. Length of stay in Baltimore 2 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township.) Baltimore
D. STREET ADDRESS (If rural, give location) I938 Lauretta Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Col.	Widower	Aug 8 I868	80 8I		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Church Creek Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Isac Ross	Rosa Dixon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Alonzo Ross	I938 Lauretta Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Congestive heart failure	2 mo.
DUE TO (B)	Hypertensive cardio-vas-Dis.	?
DUE TO (C)	Chr. Nephritis	?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Apr. 22 *, 19*49 *, to* June 24 *, 19*49 *, that I last saw the deceased alive on* June 24 *, 19*49 *, and that death occurred at* 7-10 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George McDonald M. D.	844 N. Carey St	6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/28/I949	Mt Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, MD	Elroy O. Wilson	I000 Brantly Ave.

VS 150

131B

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75736

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75736

1. NAME OF DECEASED (Type or Print): THOMAS P. KELLY

2. DATE OF DEATH: June 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1414 Mt. Royal Ave

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1414 Mt. Royal Ave 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	About 70	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Treasurer	Loyola Bldg. Assn	Baltimore, Maryland	

13. FATHER'S NAME: Martin M. Kelly

14. MOTHER'S MAIDEN NAME: Maria Bodkin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Helen L. Kelly — ADDRESS: 1414 Mt. Royal Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — Interval between onset and death: 4 days

DUE TO

(B) Chronic Hypertensive Cardio Vascular Renal Disease with Hypertension — Interval between onset and death: several years.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1949 *to* 26 June, 1949 *that I last saw the deceased alive on* 26 June, 1949, *and that death occurred at* 10 30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lauriston L. Brown M. D.	1938 Linden Ave	27 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/29/49	Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	H. H. Mears and Son	805 N. Calvert St

VS 150

131a

G75737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

Registered No. G75737

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Maggie Durkins

2. DATE OF DEATH 6/25/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland 13 11 Madison ave

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bar-Wil-Ba Convalescent Home

c. Length of stay in Baltimore 50 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Md
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16
d. STREET ADDRESS (If rural, give location) 1132 Woodyear st

5. SEX Female
6. COLOR OR RACE Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH May 11, 1885
9. AGE (In years last birthday) 64 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) A A County Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Moses Gassaway

14. MOTHER'S MAIDEN NAME Mary Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Carrie Dickerson ADDRESS 1527 Winchester st

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 3 1949, to June 25th 1949, *that I last saw the deceased alive on* June 24th 1949, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert L. Jackson M. D.
23b. ADDRESS 600 N. Arlington Ave.
23c. DATE SIGNED 6-28-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/28/49
24c. NAME OF CEMETERY OR CREMATORY Mt Auburn
24d. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Charles A. Rice
ADDRESS 661 W. Barre st

VS 150

131a

AB-129937
675738

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 9 or 8 675738 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Roderick M.King — N-805.0

2. DATE OF DEATH June 27-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Carroll County
D. STREET ADDRESS (If rural, give location) Oakland Mill Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Oct. 16-1926	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Michigan

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles King

14. MOTHER'S MAIDEN NAME Flora McIntyre

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Baltimore City Hospitals Records-4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Spinal Cord shock
DUE TO compression of the 5th. cervical vertebra
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATE APPROVED BY
John R. Davis, M.D.
Per Earl L. Rogers
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION June 26-1949

19B. MAJOR FINDINGS OF OPERATION Cervical Laminectomy and spinal cord decompression

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident

21B. PLACE OF INJURY (e. g., in or about home, factory, street, office bldg., etc.) 2500 Broening Highway Rear of Bldg. 16

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) South Rear of bldg.16-Western Electric Co.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY June 26-1949- m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Diving in water and Hurt himself

22. *I hereby certify that I attended the deceased from* 6-26- , 1949 *to* 6-27- , 1949, *that I last saw the deceased alive on* 6-27- , 1949, *and that death occurred at* 4.21 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE E. L. Rogers M. D.

23B. ADDRESS Baltimore City Hospitals

23C. DATE SIGNED 6-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 1/1949

24C. NAME OF CEMETERY OR CREMATORY Lakeside Port Huron Mich

24D. LOCATION (City, town, or county) (State) Port Huron Mich

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949

REGISTRAR'S SIGNATURE Williams, M.D.

25. FUNERAL DIRECTOR Harry J. Ninneman

ADDRESS 4204 Edgewood Rd

VS 150

TO BE APPROVED BY MEDICAL EXAMINER

186a

G75739

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75739

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Wm Creamer

2. DATE OF DEATH: 6/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 633 S. Streeper St
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Rt 1-0
D. STREET ADDRESS (If rural, give location): 633 S. Streeper St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	6-12-1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Emp. Agency	Retired	Md.	U.S.A.

13. FATHER'S NAME: ? Creamer

14. MOTHER'S MAIDEN NAME: Margaret Wagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	?	Annett Noell	same

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C.V disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: C. A. Schumake M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED: 6/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/29/49	Oak Lawn	Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 28 1949

REGISTRAR'S SIGNATURE: Lemington Williams, M.D.

25. FUNERAL DIRECTOR: Lilly & Zeiler — ADDRESS: 403 S. Wolfe St

VS 151

937

G75740

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 1 G75740 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. Be especially careful to correct age if especially important.

1. NAME OF DECEASED (Type or Print): JAMES L. SLACUM

2. DATE OF DEATH: June 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3215 Shannon Drive
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3215 Shannon Drive 26-03

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept.11, 1911
9. AGE (In years last birthday): 37 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mail Carrier
10B. KIND OF BUSINESS OR INDUSTRY: U.S.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Slacum
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Sadie Slacum — ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication, which caused death.)
(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earle Roger M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 26 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/29/49
24C. NAME OF CEMETERY OR CREMATORY: Balto. National
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Fidelity Zeiler
ADDRESS: 403 S. Wolfe St

VS 151

94a

G75741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75741 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret Horn McPherson Gettier

2. DATE OF DEATH 6/25/49

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Anderson Nurseing Home 3605 Hillsdale Rd.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. City
D. STREET ADDRESS (If rural, give location) 3605 Hillsdale Rd. 2801

5. SEX Female | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH Apr. 1-1863 | 9. AGE (In years last birthday) 86 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md | 12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME David McPherson

14. MOTHER'S MAIDEN NAME Margaret Ferguson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Walter Dandy ADDRESS 3904 Juniper Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningeal Vascular Hemorrhage — Interval between onset and death: 3 wks.

DUE TO

(B) Virus Pneumonia. — 8 wks.

DUE TO

(C) Cerebral - Arterio - Sclerosis. — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION None | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 20, 1944, *to* June 25, 1949 *that I last saw the deceased alive on* June 25, 1949, *and that death occurred at* 11.45 m., *from the causes and on the date stated above.*

23A. SIGNATURE Earl L. Chambers M. D. | 23B. ADDRESS 4109 Liberty Heights | 23C. DATE SIGNED 6/27/49.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 6/28/49 | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park | 24D. LOCATION (City, town, or county) (State) Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949 | REGISTRAR'S SIGNATURE Tuttington Williams, M.D. | 25. FUNERAL DIRECTOR John O Mitchell & Sons | ADDRESS 1900 Eutaw Pl.

John O. Mitchell

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

8 3a

G75742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75742

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BENJAMIN F. ANDERSON

2. DATE OF DEATH June 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2041 Ellsworth Street

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2041 Ellsworth Street 8-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White			61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Pile Driver	Md	U. S.

13. FATHER'S NAME John Anderson

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS Mrs. Anderson 2041 Ellsworth St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Malnutrition	
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Arteriosclerotic cardiovascular disease	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Geo. H. Merrill M.D.		6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 30th 1949	Morelands	Taylor Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, Md.	Leo B. Leach	1201-03 N. Patterson Park Ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct as gratefully supplied. age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 151

931

AB-114602-
G75743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75743
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James C. Norfolk

2. DATE OF DEATH June 26-1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 510 S. Hanover St. 22-01

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH Jan. 14- 1870
9. AGE (In years last birthday) 79 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles Norfolk
14. MOTHER'S MAIDEN NAME Elizabeth Hardesty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT 4940 Eastern Ave. ADDRESS Records-Baltimore City Hospitals

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Spontaneous Pneumothorax — Interval between onset and death: 10days

DUE TO

(B) Bronchopneumonia — 2 wks

DUE TO

(C) Pulmonary Emphysema — 2yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease — 2yrs

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-18, 1947 *to* 6-26-, 1949, *that I last saw the deceased alive on* 6-26-, 1949, *and that death occurred at* 7.10A m., *from the causes and on the date stated above.*

23A. SIGNATURE R. S. Corpus M. D.
23B. ADDRESS Baltimore City Hospitals
23C. DATE SIGNED June 26-1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 29 1949
24C. NAME OF CEMETERY OR CREMATORY Morelands
24D. LOCATION (City, town, or county) (State) Taylor Ave

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR Leo S. Cook
ADDRESS 1703 N. Patterson Park Ave

93D

G75744

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1 ✓ 334 Registered No. G75744

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Otis DAVIS

2. DATE OF DEATH 6-26

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

C. Length of stay in Baltimore 20 (Yrs.) (Mos.) (Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 430 N. Arlington Av

5. SEX M
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 3-6-1903
9. AGE (If under 1 year, last birthday) 46 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wire Drawer
10B. KIND OF BUSINESS OR INDUSTRY Steel mill
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown
16. SOCIAL SECURITY NO.
17. INFORMANT wife ADDRESS 430 N Arlington Av

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hypostatic pneumonia	1 da
DUE TO (B)	Hypertensive Encephalopathy	3 da
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

20. AUTOPSY? YES ☐ NO ☒

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION None
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) None
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? None

22. *I hereby certify that I attended the deceased from* 6-23 19 49 *to* 6-26, 19 49 *that I last saw the deceased alive on* 6-26, 19 49 *and that death occurred at* 10:05 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D. 23B. ADDRESS Provident Hosp 23C. DATE SIGNED 6-27

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 6-29-49 24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem A.A. Co 24D. LOCATION (City, town, or county) (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949 REGISTRAR'S SIGNATURE [signature] Huntington Williams, M.D.

25. FUNERAL DIRECTOR Charles G Cooper ADDRESS 512 N. Carrollton Ave

87E

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the cause of death clearly and legibly. Physician: please write correct age is especially important.

75745
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

433.1 G75745
Registered No.

1. NAME OF DECEASED (Type or Print): CARRIE A. COONEY
2. DATE OF DEATH: JUNE 25 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1159 W. HAMBURG ST.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1159 W. HAMBURG ST. 21-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	WIDOWED	JAN. 8, 871	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	OWN HOME	BALTIMORE, MD.	

13. FATHER'S NAME: JAMES CRICKER
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	NO	NO	EVA C. ARMSWORTHY	1159 W. HAMBURG ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Auricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: May 7/49 to June 25/49
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 7 1949 *to* June 25, 1949 *that I last saw the deceased alive on* June 25 1949, *and that death occurred at* 11:30 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Howard Kates M. D.	517 Cathedral St	6/27/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	JUNE 29, 1949	LOUDEN PARK	BALTIMORE, MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	Joseph T. Cowton, Jr.	1228 Light Street

VS 150

95a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75746

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

53 G75746
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Irene Hopkins

2. DATE OF DEATH: June 27 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5
D. STREET ADDRESS (If rural, give location): 514 North Clinton Street 2L-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Aug 8 1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore Md.	U.S.

13. FATHER'S NAME: Harrison Smith

14. MOTHER'S MAIDEN NAME: Mary Hughes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
no	no	Hospital record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Perforation of colon — 2 days
DUE TO following resection of Carcinoma of colon
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-22-49&6-27-49	Carcinoma of colon 2, Generalized peritonitis	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-9, 1949, *to* 6-27, 1949, *that I last saw the deceased alive on* 6-27, 1949, *and that death occurred at* 2-40 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Kirk Moore M. D.	Church Home and Hospital	6-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
July 1 1949	Buried	Oak Lawn	Colgate Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JUN 28 1949	Washington Williams, M.D.	Ulman Funeral Home Baltimore

VS 150

46E

G75747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75747

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES GLADDEN

2. DATE OF DEATH 27 June 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp.

c. Length of stay in Baltimore Wife Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 624 W Biddle 17-01

5. SEX M
6. COLOR OR RACE C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 31 May 1876
9. AGE (In years last birthday) 73
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NO
10B. KIND OF BUSINESS OR INDUSTRY NE

11. BIRTHPLACE (State or foreign country) Balto, MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jesse Gladden

14. MOTHER'S MAIDEN NAME Martha Gross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Patient
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) PROBABLE Coronary Thrombosis	15 minutes
ANTECEDENT CAUSES	DUE TO (B) Hypertensive Heart Disease	15 yrs
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION NONE
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 22 June, 1949 *to* 27 June, 1949, *that I last saw the deceased alive on* 27 June, 1949 *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE John A Ferrie M. D.
23B. ADDRESS Mercy Hospital
23C. DATE SIGNED 27 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6-28-49
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949
REGISTRAR'S SIGNATURE Huntington for Williams M.D.
25. FUNERAL DIRECTOR Mrs Frances A. Hewes
ADDRESS 57[illegible] W. Biddle St

VS 150

935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75748 GN. 129670 ✓ E 185.0 G75748

BIRTH NO. BCH-02933

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Edna Marie Cornick

V-966.9

2. DATE OF DEATH: 6- 26- 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1512 Milliman ST. Z 5 7-05

3B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

3C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Negro	S	June 19- 1944	5				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Cornick

14. MOTHER'S MAIDEN NAME: Bernice Cole

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: B.C.H. Records ADDRESS: 4940 Eastern Ave. ✓

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lead poisoning
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-15- , 1949, *to* 6- 26- , 1949, *that I last saw the deceased alive on* 6- 26- 1949 *and that death occurred at* 9.30P m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: B.C.H. 4940 Eastern Ave.

23C. DATE SIGNED: 6- 27- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 6/29/49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

24D. LOCATION (City, town, or county) (State): A. A. County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 28 1949

REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.

25. FUNERAL DIRECTOR: Peter L. Young ADDRESS: 1532 E. Monument St.

VS 150

78B

G75749

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75749

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and correct age is especially important.

1. NAME OF DECEASED (Type or Print) Albert Perkins

2. DATE OF DEATH June 25 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1013 Layfette Ave W.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 16-01
D. STREET ADDRESS (If rural, give location) 1013 W Layfette St

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX M
6. COLOR OR RACE Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH 12/15/74
AGE (In years last birthday) 74
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Perkins
14. MOTHER'S MAIDEN NAME Mary James
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Ethel Perkins ADDRESS 1013 Layfette

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure

DUE TO

(B) Arteriosclerotic cardio-vascular renal disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 18, 1949 *to* June 25, 1949 *that I last saw the deceased alive on* June 25, 1949 *and that death occurred at* 3:00 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE D. Shorofsky M.D. M. D.
23B. ADDRESS 601 N. Monroe St.
23C. DATE SIGNED 6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 28 49
24C. NAME OF CEMETERY OR CREMATORY Mt Auburn
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Isaiah L Brown Son
ADDRESS 105 S Montgomery

1 131a

BIRTH NO. 75750

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 1 Registered No. 075750

1. NAME OF DECEASED (Type or Print): CHARLES C. MILLER

2. DATE OF DEATH: June 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2902 Clearview Avenue 27-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	June 15-1895	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Natl Trucking

10B. KIND OF BUSINESS OR INDUSTRY: Genl Mgr

11. BIRTHPLACE (State or foreign country): Penna

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Miller

14. MOTHER'S MAIDEN NAME: Rosa

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Ruth Miller ADDRESS: 2902 Clearview

MEDICAL CERTIFICATION

CAUSE OF DEATH

19.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary thrombosis	
DUE TO	(B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 6-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 6-30-49

24C. NAME OF CEMETERY OR CREMATORY: Gradon Hueston

24D. LOCATION (City, town, or county) (State): Lehighton, Penna

DATE RECEIVED BY LOCAL REGISTRAR: JUN 28 1949

REGISTRAR'S SIGNATURE: Emerson Williams, M.D.

25. FUNERAL DIRECTOR: L. J. Luck ADDRESS: 5305 Harford Rd

94a

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. Be correct age is especially important.

G75751 CERTIFICATE CORRECTED 2-22-49 ✓ No. 1 G75751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): PETER FREDERICK AMER

2. DATE OF DEATH: June 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1311 Holbrook Street 9-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower Married	Mar. 26, 1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist maintainance	Brewery	Pittsburgh, Pa.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nicholas Amer	Amelia Meyers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	Spanish American	216-03-0072	Mrs. Elizabth Meyers	1311 Holbrook St.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary thrombosis
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 6-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/30/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Thurston for Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 151

94a ✓

G75752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 Registered No. G75752

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET A. EURY

2. DATE OF DEATH 6-26-49

3. PLACE OF DEATH: a. Baltimore City, Maryland b. BALTIMORE

c. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3535 GREENMOUNT Ave

c. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 9-05
D. STREET ADDRESS (If rural, give location) 3535 GREENMOUNT Ave

5. SEX: FEMALE | 6. COLOR OR RACE: WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED | 8. DATE OF BIRTH: 11-14-1871 | 9. AGE (In years last birthday): 77 78 | If under 1 year: Months, Days | If under 1 day: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME JOHN C. HECK

14. MOTHER'S MAIDEN NAME CATHERINE BAUER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MISS MARGARET A. EURY ADDRESS 3535 GREENMOUNT Ave

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-vascular-renal Disease
DUE TO
(B) Epithelioma face
DUE TO
(C) Parkinsonism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1939 19__ *to* 6-26 19 49 *that I last saw the deceased alive on* 6-25-1949 *and that death occurred at* 5:30 P. M. *from the causes and on the date stated above.*

23A. SIGNATURE C. H. Ewald Jr. M. D. | 23B. ADDRESS 96 York Ct | 23C. DATE SIGNED 6/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 6-29 | 24C. NAME OF CEMETERY OR CREMATORY BALTIMORE | 24D. LOCATION (City, town, or county) BALTIMORE (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 28 1949 | REGISTRAR'S SIGNATURE Thurlington Williams, M.D. | 25. FUNERAL DIRECTOR John G. Moran | ADDRESS 3000 E. Balt. St.

VS 150

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G75753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75753

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizab B. Hoover

2. DATE OF DEATH June 27, 1949

3. PLACE OF DEATH: Baltimore City, Maryland Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 27-16

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3115 Woodland Ave.

c. Length of stay in Baltimore, Life Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	Feb 4 1867	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dispatcher	Balto. Transit Co.	Balto. Md.	USA

13. FATHER'S NAME Abraham Hoover

14. MOTHER'S MAIDEN NAME Mary Buffer.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	None	Catherine V. Hoover	3115 Woodland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio-vascular Disease. — INTERVAL BETWEEN ONSET AND DEATH: 6 MOS.

DUE TO

(B) Senility

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	None.	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from April 11, 1949, to June 17, 1949, that I last saw the deceased alive on June 17, 1949, and that death occurred at 4:00 A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. Emmett Green M. D.	101 W. Read St. Balto.	June 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 30/49	Lorraine Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	Loring Byers	5005 Park Heights

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

G75754 New Certificate Rec. 6/27/49 ✓ 0 0 ✓ G75754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Charles Mattheu

2. DATE OF DEATH: Mar. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 309 North Point Road
C. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 309 North Point Road. 76-05

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3/25/1906
9. AGE (In years last birthday): 42
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Man
10B. KIND OF BUSINESS OR INDUSTRY: Laundry
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John L. Mattheu
14. MOTHER'S MAIDEN NAME: Laura V. Brehm

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Margaeet Mattheu (Wife)
ADDRESS: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
(B) Pulmonary Tuberculosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1948, *to* Mar. 9, 1949, *that I last saw the deceased alive on* Mar. 9, 1949, *and that death occurred at* 10 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Dr. M. A. Jacobs, M. D.
23B. ADDRESS: 617 North Point Road
23C. DATE SIGNED: 3/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/14/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Zeiler, Inc.
ADDRESS: 403 S. Wolfe St.

VS 50
Sent from State Dept.

130

Grave # 7 ✓ Eg x 9. 8

G75755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75755 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Unidentified N-990.

2. DATE OF DEATH April 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Found drowned
Fleet & E. Falls

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 3-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C			50?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Drowning DUE TO

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. ?	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Harbor	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Fleet & E. Falls St. (Harbor)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) ? m.	21E. INJURY OCCURRED WHILE AT WORK ☐ ? NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR? Found drowned 3/2

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil L. Beyer M.D.		April 27 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
		PUBLIC CEMETERY JUN 8 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 28 1949	Huntington Williams, M.D.	[illegible]	

VS 151

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G75756 ✓ E929.8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 75756

BIRTH NO. N-990

1. NAME OF DECEASED (Type or Print): STANISLAW KOZIERACKI

2. DATE OF DEATH: June 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harbor—Ft. of Caroline St. near Scott Street
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1630 Shakespeare Street 2-03

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH
9. AGE (In years last birthday): 60 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carman
10B. KIND OF BUSINESS OR INDUSTRY: B & O R.R.
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Clement Kozieracki

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Drowning
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Harbor
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Found at the Ft. of Carline Street near Scott Street
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Found: June 26, 1949 ?m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Found drowned 3/2

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.*

23A. SIGNATURE: EARL L. ROYER, M.D.
PER: H. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ / ASSISTANT MEDICAL EXAMINER ☒ / MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 6-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 29th
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Fred W. Ozazewski 1830 Eastern Ave 183

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75757 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ABRAHAM ETELSON

2. DATE OF DEATH: 6-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp.

c. Length of stay in Baltimore: 49 YRS. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-09
D. STREET ADDRESS (If rural, give location): 3800 Norfolk Avenue.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Merchant	Russia	U.S.A

13. FATHER'S NAME: Joseph Etelson

14. MOTHER'S MAIDEN NAME: Sarah Kadish

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	213-20-7530	Annie Etelson	3800 Norfolk Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure

DUE TO

(B) H A-S C.V.D

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bronchiogenic ca ? metastases

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-3 1949 *to* 6-28 1949, *that I last saw the deceased alive on* 6-28 1949 *and that death occurred at* 11A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benj K Silverman M. D.	Sinai Hosp.	6-28

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/29/49	Bros. Israel Corp.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Tuttington Williams, M.D.	S. Levinson & Bros.	1124 W. North Ave.

VS 150

4Tc

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not guess, but correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77 G75758

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rubin Levin

2. DATE OF DEATH June 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3700 Cottage Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 46 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3700 Cottage Ave

1F-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shoe Maker		Russia	

13. FATHER'S NAME: Meyer Baer Levin

14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Sol Levin — ADDRESS: 1510 W Baltimore St

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

(B) Carcinoma of Prostate Gland. 1½ Yrs

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/24, 1947, *to* June 28, 1949, *that I last saw the deceased alive on* June 28, 1949 *and that death occurred at* 7 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sol Smith M. D.	1223 E North Ave	6/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 29, 1949	Bnai Israel Cemetery	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams, M.D.	Sol Levinson & Bros	1126 W North Ave

VS 150

513

G75759

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C.49-11565 CERTIFICATE OF DEATH 76 Registered No.

G75759

1. NAME OF DECEASED (Type or Print): Baby Elliott

2. DATE OF DEATH: 6/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctors, Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1109 Washington, Blvd. 21-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White		6/11/49				1	30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ernest Ludwig Elliott
14. MOTHER'S MAIDEN NAME: Edith May Quarles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ernest Elliott ADDRESS: 1109 Washington, Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-11-1949 *to* 6-11-1949, *that I last saw the deceased alive on* 6-11-1949, *and that death occurred at* 3:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Louis Hyman M. D.
23B. ADDRESS: 816 Wolfe St
23C. DATE SIGNED: 6/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: JOHNS HOPKINS MEDICAL SCHOOL JUN 13 1949
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JUN 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75760 1118 ✓ 774 G75760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C.49-11118 Registered No.

1. NAME OF DECEASED (Type or Print) John Charles Guilfoy

2. DATE OF DEATH June 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

c. Length of stay in Baltimore life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 29 25-31

D. STREET ADDRESS (If rural, give location) 445 Randon Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	S.	May 31, 1949		4 3	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Guilfoy

14. MOTHER'S MAIDEN NAME Doris Drury

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Doris Guilfoy ADDRESS 445 Randon Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Malignant Hypertension C-V Dis. in Mother - Pregnancy terminated by Cesar. Section.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* May 31, 1949, *to* 6-3-, 1949, *that I last saw the deceased alive on* 6-3-, 1949, *and that death occurred at* 4:00 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leo M. Seltz M. D.	Sinai Hosp. Balto.	6-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL JUN 7 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and correct age is especially important.

159

675761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

675761

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Annie Bond Smith

2. DATE OF DEATH June 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1117 Valley St

c. Length of stay in Baltimore 83 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City.
D. STREET ADDRESS (If rural, give location) 1117 Valley St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Dec 18, 1865	83	6	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home Keeping	At Home	Baltimore Md	U.S.A.

13. FATHER'S NAME Dr Laurence J. Smith

14. MOTHER'S MAIDEN NAME Annie McWilliams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Mr Charles F. Sullivan	1400 Rosedale Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

(B) age. Hemorrhaged Arteriosclerosis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
—	—	—

22. *I hereby certify that I attended the deceased from* June, 1939 *to* June 27, 1949 *that I last saw the deceased alive on* June 26, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas Schultz M.D.	545 Fulton Ave	6-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 30 1949	Greenmount Ave	Baltimore City Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams M.D.	Edward W. Conklin	924 E Eager St.

VS 150

930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75762

Registered No.

BIRTH NO. B.C. 49-11316

1. NAME OF DECEASED (Type or Print) Baby Girl Seymar

2. DATE OF DEATH 6/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25
D. STREET ADDRESS (If rural, give location) 5209 Brookwood Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	6/2/49			1

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Seymar	Christine Brenner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia

DUE TO

(B) Premature Separation of Placenta

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/2/49, 19__, *to* 6/3/49, 19__, *that I last saw the deceased alive* 6/3/49 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	1213 Light Street	6/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY (City, town, or county) (State)
		[redacted] JUN 1 4 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL [redacted] ADDRESS
JUN 29 1949	Huntington Williams, M.D.	

VS 150

160c

G757b3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G757b3

BIRTH NO. BC 49-12107

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Leovell

2. DATE OF DEATH: June 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: 2 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17
D. STREET ADDRESS (If rural, give location): 1602 Park Avenue 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	S.	June 11, 1949		2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Shirley Smith
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Shirley Leovell — ADDRESS: 1602 St. Paul St. 17

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis
DUE TO
(B)
DUE TO
(C) Prematurety

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 11, 1949 to June 12 1949, that I last saw the deceased alive on June 12 1949, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE: L. A. Warren M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: June 14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): JUN 15 1949

DATE RECEIVED BY LOCAL REGISTRAR: JUN 29 1949
REGISTRAR'S SIGNATURE: Tyntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

VS 150

159

075704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

075704

BIRTH NO.

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Ruth Elliott

2. DATE OF DEATH: 27 June 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — 741 McHenry
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 51 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 741 Mc Henry St — 21-0.1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 1 Day: Hours / Min.
Female	White	Widowed	? 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	St Mary County	Yes

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—		—

17. INFORMANT: Mrs Shannon — ADDRESS: 704 Portland St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio-Vascular Disease

DUE TO
(B)

DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☑ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Wm. H. Kemmer Jr. M.D.		27 June 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	June 31-49	Ladies Star of Sea	Solomons Island Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams, M.D.	Joseph Kaminskas Jr.	602 Wash. Blvd

VS 151

937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

Registered No. G75765

BIRTH NO. G75765

1. NAME OF DECEASED (Type or Print) Julius Dickman

2. DATE OF DEATH 6-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-03
D. STREET ADDRESS (If rural, give location) 1709 Ruxton Ave

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M

8. DATE OF BIRTH

9. AGE (In years last birthday) 68 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY Real Estate

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Morris

14. MOTHER'S MAIDEN NAME Esther

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Jennie Dreckman ADDRESS 1709 Ruxton

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema

DUE TO

ANTECEDENT CAUSES

(B) H A-S C-VD

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-20, 1949, *to* 6-20, 1949, *that I last saw the deceased alive on* 6-20, 1949, *and that death occurred at* 7:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE Benj. K Silverman M. D.

23B. ADDRESS Sinai Hosp.

23C. DATE SIGNED 6-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6-28-49

24C. NAME OF CEMETERY OR CREMATORY Rosedale

24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUN 29 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Lewis Inc

ADDRESS 2100 Eutaw Pl

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be exact age in especially important. Physician: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

075766

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 075766

1. NAME OF DECEASED (Type or Print): MATTIE ENOCH

2. DATE OF DEATH: May 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 402 N. Pine Street 1703

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	U	U	36				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	K	K	

13. FATHER'S NAME: O

14. MOTHER'S MAIDEN NAME: O

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		N	N	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hyperplasia of the endometrium

DUE TO

(B) Adeno-carcinoma of the uterus

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: William J. McCafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 5-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL JUN 9 1949

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JUN 29 1949

REGISTRAR'S SIGNATURE: [illegible] Washington Williams, M.D.

25. FUNERAL DIRECTOR: [illegible] Commissioner of Health

ADDRESS

VS 151

56 B

G75767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

G75767 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HASTY DICKENS

2. DATE OF DEATH 6/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 136 W. Cross St

c. Length of stay in Baltimore 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore -
D. STREET ADDRESS (If rural, give location) 136 W Cross St 2-3-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col		1868	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. W.

10B. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) N. Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Silas Grant

14. MOTHER'S MAIDEN NAME Clara Ballou

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Clara Williams ADDRESS Detroit - Mich

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocardites

DUE TO

(B) Hypertension

DUE TO

(C) arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 6/20-1948 *to* 6/25, 1949 *that I last saw the deceased alive on* 6/24, 1949, *and that death occurred at* 7 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE David Grauden M. D.

23B. ADDRESS 1111 Seo

23C. DATE SIGNED 6/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) 24B. DATE 6/29-49

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cmty

24D. LOCATION (City, town, or county) (State) Balto

DATE RECEIVED BY LOCAL REGISTRAR JUN 29 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Walter B. Griffith

ADDRESS 1394 Hamburg St

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

G75768

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75768

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Physician: please write the cause of death clearly and legibly. Use no ditto marks. Be specific and important.

1. NAME OF DECEASED (Type or Print) JAMES ELLIS

2. DATE OF DEATH May 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4312 Leeds Avenue

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): U N K N O W N
8. DATE OF BIRTH: U N K N O W N
9. AGE (In years last birthday): 75 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage
DUE TO
(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED May 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL JUN 1 1949
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY JUN 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Commissioner of Health
ADDRESS

VS 151

83a

675789 Jl- 12727 675789

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

177 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George Washington (Geo. Frank Washington)

2. DATE OF DEATH 6-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore 16 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1804 Brunt St. 14-03

5. SEX M
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 1 1 1880
9. AGE (In years last birthday) 68 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md. - Prince George Co.,
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Peter
14. MOTHER'S MAIDEN NAME Charlotte

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT B. C. H. Records, ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of prostate & Metastasis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ No NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-13-33, 19__, *to* June 28, 1949, *that I last saw the deceased alive on* June 28, 1949. *and that death occurred at* 2.15 am., *from the causes and on the date stated above.*

23A. SIGNATURE R. A. Dozer M. D.
23B. ADDRESS 4940 Eastern Ave.
23C. DATE SIGNED 6-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6-30-49
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn
24D. LOCATION (City, town, or county) (State) Baltimore 30. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS W. A. JACKSON - 916 PENNA. AVE.

VS 150

510

G75770

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

401 3 G75770 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HOWARD FREDERICK JONES

2. DATE OF DEATH June 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 238 N. Payson St.
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 238 N. Payson St. 20-01

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Aug. 28, 1915
9. AGE (In years last birthday) 33 yrs. If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agt.
10B. KIND OF BUSINESS OR INDUSTRY Retail Dairy Business
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Howard Andrew Jones
14. MOTHER'S MAIDEN NAME Carol Otley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-03-7504
17. INFORMANT Mrs. Arlene Jones ADDRESS 238 N. Payson St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Rheumatic Heart - mitral Stenosis	3 yrs.
	DUE TO Auricular fibrillation	?
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Rheumatic Fever	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* March, 1935 *to* June 26, 1949 *that I last saw the deceased alive on* June 23, 1949, *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE Samuel Silverfels M. D.
23B. ADDRESS 714 E. Preston St
23C. DATE SIGNED 28 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/29/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
24D. LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR WM. J. TICKNER & SONS
ADDRESS Balto., Md.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physician: please write the cause of death clearly and legibly.

923

G75771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

G75771

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN K. SKILLING

2. DATE OF DEATH June 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1700 Regent Road, Mt. Washington

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1700 Regent Rd., Mt. Washington

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	July 3, 1874	74 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	Railroad	Philadelphia, Pa.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Skilling	Mary Kane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		no	Mrs. Emma K. Skilling	1700 Regent Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Gradual

DUE TO Myocarditis.

(B) Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct *, 1943 to* June 27, 1949 *that I last saw the deceased alive on* June 26, 1949 *, and that death occurred at* 1 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. H. Healy M. D.	1403 Park ave	June 28 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/30/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and forcibly.

G75772

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 G75772 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print)	ANNA ELIZABETH OHM
2. DATE OF DEATH	June 27, 1949
3. PLACE OF DEATH: A.	Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	3049 Abell Ave.
C. Length of stay in Baltimore (Yrs. Mos. Days)	3
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Md.
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	3049 Abell Ave.
5. SEX	female
6. COLOR OR RACE	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	Widow
8. DATE OF BIRTH	Sept 28, 1868
9. AGE (In years last birthday)	80 yrs.
If Under 1 Year: Months / Days	
If Under 24 Hours: Hours / Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	h
10B. KIND OF BUSINESS OR INDUSTRY	home
11. BIRTHPLACE (State or foreign country)	Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Adolph Steeger
14. MOTHER'S MAIDEN NAME	Elizabeth Kroll
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	no
16. SOCIAL SECURITY NO.	no
17. INFORMANT	Mrs. H. E. Weaver So. Euclid, Ohio 4201 Princeton Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dehydration - 2 ' — INTERVAL BETWEEN ONSET AND DEATH: 1 week.

DUE TO

(B) Hypertension & Cerebral Hemorrhage - — Several years

DUE TO

(C) Gradual degeneration Muscular System & inability to aid self. — 3 or 4 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-10 -, 1937 *to* June 27, 1949 *that I last saw the deceased alive on* May 14, 1949, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Hedeman Baetjer M. D.	723 Medical Arts Bldg. Balto.	7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	6/30/49	Loudon Park	Balto., Md.	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS	
JUN 29 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.	

VS 150

83a

AB-46314

G75773
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.0 G75773
Registered No.

1. NAME OF DECEASED (Type or Print): James T. Robinson

2. DATE OF DEATH: 6-1-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
4940 Eastern Ave.

C. Length of stay in Baltimore: 34 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-12
D. STREET ADDRESS (If rural, give location): Baltimore City Hospitals (Infirmary
No Home- 4940 Eastern Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	Sept. 16- 1871	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maine	

13. FATHER'S NAME: Michael Robinson

14. MOTHER'S MAIDEN NAME: Sarah Connelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Baltimore City Hospitals
Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — Interval between onset and death: ½ Hour

DUE TO

(B) Arteriosclerotic Heart Disease — 8 Yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-7- , 19 39 *to* 6-1- , 19 49 *that I last saw the deceased alive on* 6-1- , 19 49 *and that death occurred at* 4.35A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. L. Rogers M. D.	Baltimore City Hospitals	6-6- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	JUN 7 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

93D

BIRTH NO. 5774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 5774

1. NAME OF DECEASED (Type or Print): ROSE DYER

2. DATE OF DEATH: June 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pasadena
D. STREET ADDRESS (If rural, give location): Pasadena Rd, Pasadena Md

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	If under 1 day: Days	If under 24 hours: Hours	Min.
Female	White	Widow	Apr 15/91	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	W. Va	

13. FATHER'S NAME: Glazie Kincard

14. MOTHER'S MAIDEN NAME: Martha O'bonnor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	

17. INFORMANT: Mrs. Zella Misek ADDRESS 966 W. Lafayette St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		6-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 2/49	Baltimore	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams, M.D.	Philip Herring Sons	2029 Eutaw St

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93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75775 BALTIMORE CITY HEALTH DEPARTMENT G75775

CERTIFICATE OF DEATH

Registered No. 443

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Henry Jones

2. DATE OF DEATH June 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital
C. Length of stay in Baltimore 20 Yrs. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 435 N. Gilmor St. 19 01

5. SEX M
6. COLOR OR RACE C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 14.86
9. AGE (In years last birthday) 62 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Durham N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Seaton Jones
14. MOTHER'S MAIDEN NAME Sarah Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Para Lee ADDRESS 435 N. Gilmore St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive cardiovascular disease.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE George S. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/29/1949
24C. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Elroy C. Wilson ADDRESS 1000 Brantly Ave.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

935

975776 ✓ 975776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELLEN M. HOLDEN

2. DATE OF DEATH: 6/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 905 N. Dukeland St
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 905 N. Dukeland St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year last birthday)	If under 1 Year Months	Days	If under 24 hours Hours	Min.
Female	White	Widow	6/13/1867	82				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H. Wife		Baltimore Md	

13. FATHER'S NAME: ? Spencer

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Alden L. Holden	905 Dukeland St

MEDICAL CERTIFICATION

18.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Occlusion	1 day
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Cardio Vascular Disease	3 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) Bronchial Asthma	25 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/27/49, to 6/27/49, *that I last saw the deceased alive on* 6/27/49, *and that death occurred at* 1:50 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.: Eliot W. Atkinson

23B. ADDRESS: 3432 Dukeland Ave

23C. DATE SIGNED: 6/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)	25. FUNERAL DIRECTOR
Burial	6/30/49	Forrest Park Cem.	Woodlawn Md	Pratt & Stricker

DATE RECEIVED BY LOCAL REGISTRAR: JU[illegible] 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75777 — V-176 — G75777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician, please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): SARAH DAVIDSON FRYE

2. DATE OF DEATH: June 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 329 S. Macon St.
c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 329 S. Macon St. 76-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	July 8, 1871	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Kentucky	

13. FATHER'S NAME: Jonathan D. Hale

14. MOTHER'S MAIDEN NAME: Jane Story

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		None

17. INFORMANT — ADDRESS: Mrs Annie McQueen, 329 S. Macon St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastasis of Sigm. Cancer — DUE TO

(B) Sigmoid Cancer — DUE TO

(C) over

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1948 *to* Feb 5 1949, *that I last saw the deceased alive on* Feb 5 1949, *and that death occurred at* 5 *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. Tramsott M. D. | 23B. ADDRESS: 623 E. N. Avenue | 23C. DATE SIGNED: 6/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/30/49	Oak Lawn.	Baltimore County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 29 1949 VS 150

REGISTRAR'S SIGNATURE: Littleton Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1207 St. Paul St.

49E

G75778 ✓ G75778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RICHARD MURTHEH

2. DATE OF DEATH June 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 540 North Calvert Street 11-61

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	UnKnown	About 1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UnKnown	UnKnown	UnKnown	

13. FATHER'S NAME UnKnown

14. MOTHER'S MAIDEN NAME UnKnown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
UnKnown	UnKnown	UnKnown	Catholic Charities	

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteric-sclerotic C.V. Disease	
DUE TO		
ANTECEDENT CAUSES (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Paul L Royer M.D.		June 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/29/49	Cathedral	Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
	Huntington Williams, M.D.	Wm Cook Inc	1217 St. Paul St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

VS 151

937 ✓

G75779

G75779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SOL Schleisner,

2. DATE OF DEATH June28th.194

3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Temple Garden Aprts 1802 Eutaw place.

C. Length of stay in Baltimore Lifetime. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Same, B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 14-03

D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widower.	Nov.18-1861.	87	7	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deprt.Store,

10B. KIND OF BUSINESS OR INDUSTRY Deprt,Store Owner,

11. BIRTHPLACE (State or foreign country) Balto.Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Emanuel Schleisner

14. MOTHER'S MAIDEN NAME Marie Krauskopf.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Lewis M.Hess. ADDRESS 4001 Fords Lane

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

(B) Coronary sclerosis — 3 yrs

DUE TO

(C) Carcinoma of stomach — 2 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) no

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 26 19[illegible], *to* June 28 19[illegible], *that I last saw the deceased alive on* June 28, 1949, *and that death occurred at* 6A *m., from the causes and on the date stated above.*

23A. SIGNATURE J. Frederick Leitz M. D.

23B. ADDRESS Temple Gardens

23C. DATE SIGNED June 26-49

24A. BURIAL, CREMATION, REMOVAL (Specify) 24B. DATE June 29th

24C. NAME OF CEMETERY OR CREMATORY 1949, Balto.Hebrew,

24D. LOCATION (City, town, or county) (State) Balto.Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 29 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Harry Goodman & Son ADDRESS 1902 Eutaw Pl

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered correctly and legibly. Physician please write the cause of death clearly and legibly. Please write the cause of death clearly and legibly. Physician please write the cause of death clearly and legibly.

Was under care of Dr. Erwin E Mayer - for about one year
D. Maya was notified to have Dr J was called in the year 47

CERTIFICATE CORRECTED 7-8-49. ✓

G75780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47-1

Registered No. G75780

BIRTH NO. G75780

1. NAME OF DECEASED (Type or Print): Elizabeth Jane Haynie

2. DATE OF DEATH: 6/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 108 Warren Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 108 Warren Ave 22-01

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 6/6/1871
9. AGE (In years last birthday): 77
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Buchannan

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Melvin Haynie
ADDRESS: 212 11th Ave

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C.-V. Disease — Interval between onset and death: 18 mos.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cerebral Accident (mild) — 1 day

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/23 *1949 to* 6/27 *, 1949 that I last saw the deceased alive on* 6/27 *, 1949 and that death occurred at* 11:05 a *m., from the causes and on the date stated above.*

23A. SIGNATURE: C. F. Richter M. D.
23B. ADDRESS: 11 W. Biddle St.
23C. DATE SIGNED: 6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6/30/49
24C. NAME OF CEMETERY OR CREMATORY: Glen Haven
24D. LOCATION (City, town, or county) (State): Glenburnie, Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 29 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: John F. Dennywitz
ADDRESS: 711 Light St.

VS 150

93D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75781

BIRTH NO. 75781

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type or correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): John Henry Leonard

2. DATE OF DEATH: June 27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3719 Nortonia
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3719 Nortonia Rd
C. Length of stay in Baltimore: 40 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore Md 15-09
D. STREET ADDRESS (If rural, give location): 3719 Nortonia Rd

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: July-7-1888
9. AGE (In years last birthday): 60 61 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Building Business
10B. KIND OF BUSINESS OR INDUSTRY: Builders
11. BIRTHPLACE (State or foreign country): Phila-Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Charles Leonard
14. MOTHER'S MAIDEN NAME: Charlotte — ? —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 220-07-5228
17. INFORMANT: Adele L. Graf (Daughter) ADDRESS: 264 W Lafayette

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: [illegible] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: June 30/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Stewart Mortuary
ADDRESS: Balto.

VS 151

94a

AB-129956

5782
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 075782

1. NAME OF DECEASED (Type or Print) Isaiah Conyer

2. DATE OF DEATH June 28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore — Yrs. Life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1127 N.Gilmore St.

5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov.7- 1897
9. AGE (In years last birthday): 51
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS
Baltimore City Hospitals Record-4940 Eastern Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Far advanced Pulmonary Tuberculosis ~~with~~ & Miliary Spread — 3 Mos-plus

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [Yes] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-27- , 1949 *to* 6-28- , 1949 *that I last saw the deceased alive on* 6-28- 1949 *, and that death occurred at* 10.05 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE C. A. Dozan M. D.
23B. ADDRESS Baltimore City Hospitals
23C. DATE SIGNED 6-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE 6-30-49
24C. NAME OF CEMETERY OR CREMATORY Balto. National
24D. LOCATION (City, town, or county) (State) Balto. City

DATE RECEIVED BY LOCAL REGISTRAR JUN 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS Samuel W. Sullivan Jr. Balto

VS 150

No. [redacted]

1313

G75783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 G75783

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Lillian Belle Scriber

2. DATE OF DEATH June 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 921 N. Gay St.

C. Length of stay in Baltimore 52 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 921 N. Gay St. 10-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow	July 14, 1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Benjamin Brown

14. MOTHER'S MAIDEN NAME Florence Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mr. Joseph Scriber ADDRESS 921 N. Gay St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis

DUE TO (B) Hepatitis & Nephritis

DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH 8 wks.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-5-49 *to* 6/26, 19 49, *that I last saw the deceased alive on* 6-26 19 49, *and that death occurred at* 11:45 A. M., *from the causes and on the date stated above.*

23A. SIGNATURE Jas. R. Blake M. D. 23B. ADDRESS 1603 N. Carolina 23C. DATE SIGNED 6/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 6/30/1949 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUN 29 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Holland Funeral Home ADDRESS 1681 Druid Hill Ave

93E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BIRTH NO. G75784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

760 Registered No. G75784

1. NAME OF DECEASED (Type or Print): Estella Stowers Rich

2. DATE OF DEATH: June 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1315 Winchester St

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto City 16-0
D. STREET ADDRESS (If rural, give location): 1315 Winchester St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	married	Dec 25, 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Va

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Fleet Penny

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Walter Rich ADDRESS: 1315 Winchester St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemmorhage

DUE TO

(B) Hypertension Nephritis

DUE TO

(C) Diabetes Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/10 1949 *to* 6/27 1949 *that I last saw this deceased alive on* 6/26 1949 *and that death occurred at* 4P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: Dan Grumbine M. D.

23B. ADDRESS: Mt Vernon Sq

23C. DATE SIGNED: 6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 1, 1949	Warsaw Va	Va

DATE RECEIVED BY LOCAL REGISTRAR: JUN 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: George A. Kelson ADDRESS: 1203 Pennsylvania Ave

VS 150

61

G75785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75785

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (LONI HUMPHREYS) LONNIE HUMPHRIES

2. DATE OF DEATH June 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 815 North Calhoun Street 16-02

5. SEX male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Unknown
8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 45
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ga.
12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME Buddie Humphries
14. MOTHER'S MAIDEN NAME Sarah Newsom

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Mamie Shannon ADDRESS 811 N Mount St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Carl L Rose M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED June 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE June 30-1949
24C. NAME OF CEMETERY OR CREMATORY Dallo National
24D. LOCATION (City, town, or county) (State) Baltimore City

DATE RECEIVED BY LOCAL REGISTRAR JUN 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Robert W Williams
ADDRESS 1515 Mordecai St 94a

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75786 BALTIMORE CITY HEALTH DEPARTMENT G75786

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **John C. Wolff**

2. DATE OF DEATH **June 27/49**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**
B. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **140 S. Collins Ave.**
c. Length of stay in Baltimore **Life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **140 S. Collins Ave.** 20-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	**White**	**Married**	**Aug. 17, 1888**	**60**		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sheet Metal Worker	**Wm. F. Zeller & Co.**	**Baltimore, Md.**	

13. FATHER'S NAME **Frederick Wolff**

14. MOTHER'S MAIDEN NAME **Frances Raabe**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	216 09 6904	**Mrs. Edith M. Wolff, 140 S. Collins Ave.**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) **Coronary Thrombosis.** — Interval between onset and death: **7 hours.**
DUE TO
(B) **Coronary Sclerosis** — **2 yrs (?)**
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **10-11**, 19**47** *to* **6-27**, 19**49**, *that I last saw the deceased alive on* **6-27**, 19**49**, *and that death occurred at* **12:50** p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Milton K. Gallagher M. D.	**Catonsville 28, Md.**	**6-28-49**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**June 30/49**	**Lorraine Park**	**Woodlawn, Md.**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	**Huntington Williams, M.D.**	**Harry H. Deitzler**	**4101 Edmondson Ave.**

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every answer must be complete. Any information missing or obviously incorrect may delay burial. Physician: please write the cause of death clearly and legibly.

G75787 G75787

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) HIRAM LESTER DARDEN

2. DATE OF DEATH June 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1432 Holbrook Street
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 32 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1432 Holbrook Street, City.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Maryland City.
D. STREET ADDRESS (If rural, give location) 1432 Holbrook Street. 9-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	Under 1 Year: Months	Days	Under 24 Hours: Hours	Min.
Male	White	Widowed	March 21, 1884	65	3	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Operator Chemical, D.	Davidson Chemical Co	Virginia	U.S. A.

13. FATHER'S NAME
Richard F. Darden

14. MOTHER'S MAIDEN NAME
Elizabeth Ricks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-07-7805A

17. INFORMANT Rena Herbst ADDRESS 1511 Collington Ave,

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Heart Disease, chronic
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 4 yrs 4 months
(B) Unknown
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 21 May, 1949, *to* 17 June, 1949, *that I last saw the deceased alive on* 19 June, 1949, *and that death occurred at* 10:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE Howard Rodman M. D.
23B. ADDRESS 1513 N. Milton Ave
23C. DATE SIGNED 28 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 30, 1949	Baltimore Cemetery	North & Milton Ave's.

DATE RECEIVED BY LOCAL REGISTRAR JUN 29 1949
REGISTRAR'S SIGNATURE Tunstall Williams, M.D.
25. FUNERAL DIRECTOR George J. Ruth ADDRESS 1735 Harford Ave.

94a

G75788 ✓ | G75788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print) HELFRICH P.E. RAABE

2. DATE OF DEATH JUNE 27 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 315 S. FRANKLINTOWN RD.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

C. Length of stay in Baltimore 68 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 20-04 315 S. FRANKLINTOWN RD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	WHITE	MARRIED	12-26-80	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER	B.&O. R.R.	BALTIMORE MD.	U.S.

13. FATHER'S NAME: FREDERICK RAABE

14. MOTHER'S MAIDEN NAME: LOUISA RAABE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	R.R. RET.	MRS. EDITH A. RAABE	315 S. FRANKLINTOWN RD

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) ARTERIOSCLEROTIC C.V.D.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug, 1948 *to* June 26 1949 *that I last saw the deceased alive on* 6/26, 1949, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Pound M.D.	3325 Frederick Ave	6/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	6-30-49	WESTERN CEM.	BALTIMORE MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams, M.D.	Geo. L. Berger Jr.	1512 Nolliston St.

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and fully.

G75789

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75789 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MRS. MARIE L. ARNOLD

2. DATE OF DEATH 6-28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. Length of stay in Baltimore 2 da. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
STATE Maryland COUNTY Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sykesville - R.D. #1
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	Married	12/29/1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		maryland	U S A

13. FATHER'S NAME Alphonsus Provost

14. MOTHER'S MAIDEN NAME Phelps

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT Miss Loretta Arnold ADDRESS 2638 W. Franklin St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure — (INTERVAL BETWEEN ONSET AND DEATH) ? weeks

DUE TO

(B) Arteriosclerotic CVD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/27 1949 to 6/27 1949, *that I last saw the deceased alive on* 6/28 1949, *and that death occurred at* 10 50 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert J. Levitas M. D.	St. Agnes Hospital	6/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/1/49	New Balto. Meth. Cem.	5501 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949 VS 150	Evington Williams, M.D.	John J. Cowan & Son	Hollins St.

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

Dr. Haase G75790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75790 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma V. Johnson

2. DATE OF DEATH: June 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1918 E. Belvedere Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1918 E. Belvedere Avenue 27-38

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
female	white	widowed	Apr. 22, 1868	81				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Md.	

13. FATHER'S NAME: Samuel Smith

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Wm. L. Johnson, ADDRESS: 1918 E. Belvedere

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 40 mins.

DUE TO

(B) Coronary occlusion

DUE TO

(C) Arteriosclerotic C.V.D.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Carcinoma left breast

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1943 *to* June, 1945, *that I last saw the deceased alive on* June 29, 1945, *and that death occurred at* 6:10 A. *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Henry Haase M.D. M. D.	4218 Harford Rd	6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-2-49	Mt. Olivet Cem	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Langston Williams M.D.	Leonard J. Ruck,	5305 Harford Road.

50

PLEASE WRITE PLAINLY, with unfading ink. Envelope will be furnished for returning supplies. Fill correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75791 BALTIMORE CITY HEALTH DEPARTMENT 144 G75791

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Robert C. Brown

2. DATE OF DEATH 6/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 610 S. Green St

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22 02
D. STREET ADDRESS (If rural, give location) 616 S. Green St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	Cld	Married	Oct 14, 1897	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	None	A. R. Co. Maryland	U. S. A.

13. FATHER'S NAME Daniel Brown

14. MOTHER'S MAIDEN NAME Lizzie Gardner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT Estella Brown - Greene St ADDRESS 610 S

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of mouth

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 year

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	

22. *I hereby certify that I attended the deceased from* 6/6, 1949 to 6/27, 1949 *that I last saw the deceased alive on* 6/26, 1949, *and that death occurred at* 2a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Traverse M. D.	1212 W Lee St	6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	6-30-49	Mt Auburn Cem.	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams, M.D.	Mrs Katie R Williams	322 N Schroeder St

JUN 29 1949

45c

G75792

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 43

G75792

Registered No.

1. NAME OF DECEASED (Type or Print): Jeremiah Jerry Wright

2. DATE OF DEATH: 6-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1628 W. Mulberry ST

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bal To. 19-01
D. STREET ADDRESS (If rural, give location): 1628 W. Mulberry ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Male.	Col.	Married	Nov. 3, 1896	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Gas. Co.	Harmons Md	U.S.A.

13. FATHER'S NAME: Wilber Wright

14. MOTHER'S MAIDEN NAME: Caroline ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No.		

17. INFORMANT: Lillian Wright ADDRESS 1628 W Mulberry St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis

DUE TO

(B) Hypertension Nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour), OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	/

22. *I hereby certify that I attended the deceased from* 1/10, 1949 *to* 6/28, 1949 *that I last saw the deceased alive on* 6/27, 1949 *and that death occurred at* 2 a *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Frankel M. D.	1122 N Eden St	6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-1-49	Sainte Rest Cem.	Harmons Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Mrs. Katie R. Williams ADDRESS 32 N Schroeder St

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75793 ✓ G75793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 591.0

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Margaret Daniels

2. DATE OF DEATH 6-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1303 13-S. Schroeder

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Married	Oct. 20, 1904	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	Baltimore, Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jeff Smith	Fannie Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Samuel H. Daniel	Schroeder St

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis of Liver
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-20- 19 49 *to* 6-26 , 19 49 *that I last saw the deceased alive on* 6-26 19 49 *and that death occurred at* 10:5 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. Brady M. D.	Provident Hospital	6-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 29, 1949	Mt. Auburn	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams, M.D.	Mrs Katie R. Williams	322 N Schroeder St

VS 150

124B

G75794 G75794

BIRTH NO. G75794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Samuel Butler

2. DATE OF DEATH: 6/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1113 Argyle ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1113 Argyle ave 17-27

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Cld	Married	Sept 13 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Porter		Batto. Maryland	U.S.A

13. FATHER'S NAME: Elijah Butler

14. MOTHER'S MAIDEN NAME: Mary Frazier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	—	

17. INFORMANT: Lelia Butler ADDRESS 1113 Argyle Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ch. Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2

DUE TO

(B) Myocardial Failure — 2

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-28, 1949, *to* 6/27, 1949, *that I last saw the deceased alive on* 6-27, 1949 *and that death occurred at* 1:30 P.M. *from the cause and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter Wood M. D.	849 Hanlon	6-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 30, 1949	Mt. Auburn	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 29 1949

REGISTRAR'S SIGNATURE: [redacted]

25. FUNERAL DIRECTOR: Mrs Kate R. Williams ADDRESS 322 N Schroeder St

VS 150

925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

BIRTH NO. G75795

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75795

1. NAME OF DECEASED (Type or Print): Mose Ellis Jr

2. DATE OF DEATH: June 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 223 W. Hill Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 25-Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 223 W. Hill Street 22-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	W	10/25/1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Self	Virginia	

13. FATHER'S NAME: Mose Ellis

14. MOTHER'S MAIDEN NAME: Hattie-?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT — ADDRESS: Revedy Brooks, 223 W. Hill Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Acute Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
Influenza — 2 weeks
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased May 16, 19[illegible], to June 28, 19[illegible], that I last saw the deceased June 28, 19[illegible], and that death occurred at [illegible] m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. Lincoln Shelton M. D.	908 E. Chase St.	6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/29/49	Mt Auburn Ct	Baltimore, City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams, M.D.	L. L. Brown & Son	104 W Montgomery St

VS 150

33a

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not guess. Write the cause of death clearly and forcibly. Physicians: please write this important.

G75796 ✓ G75796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4/20

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Edward Himes

2. DATE OF DEATH: 6/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3503 Menlo Drive
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 3503 Menlo Dr. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 3503 Menlo Drive 27-20

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Dec. 1905	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician	Md. Dry Dock	Baltimore	

13. FATHER'S NAME: John N. Himes

14. MOTHER'S MAIDEN NAME: Rosa Ridgeway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1922-26	212-03-2769	Elizabeth Himes	3503 Menlo Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Angina Pectoris — INTERVAL BETWEEN ONSET AND DEATH: 1½ mo

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* MAY 10, 1949 *to* June 28, 1949, *that I last saw the deceased alive on* 6/28, 1949, *and that death occurred at* 3:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lee J. Volenick M. D.	4710 Liberty Hts Ave	6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/30/49	Balto. National	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams, M.D.	M. Fahey & Sons	1827 W. North Ave.

VS 150

94B

Every item of information should be answered. If unknown, "unknown" should be stated. Physician: please write the cause of death clearly and legibly. Exact age is especially important.

G75797 ✓ G75797

G75797 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 451

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Florence Power Dukehart

2. DATE OF DEATH June 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4011 Alto Road

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4011 Alto Rd. 15-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Feb. 17, 1868	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Maryland	

13. FATHER'S NAME: Edward Power

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		no	Mr. Donald Dukehart	500 Bosley Ave. Towson, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dissecting Aneurism — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Abdomenal Aortic Aneurism

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* December 1948 *to* June 28, 1949 *that I last saw the deceased alive on* June 28, 1949 *and that death occurred at* 10:58 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lester A. Stall Jr. M. D.	2950 Edmondson Ave	June 28 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	6/30/49	Woodlawn Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

30D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if obtainable. Do not guess, but correct age is especially important. Physician please write the cause of death clearly and legibly.

G75798

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75798 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie Bailey

2. DATE OF DEATH: June 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1538 McElderry St

c. Length of stay in Baltimore: 22 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1538 McElderry St 7-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	C.	Widow	Dec 4 1875	73 74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pocomoke City Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: Julia Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Julia Bailey ADDRESS: 1538 McElderry

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician please write the correct age is especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular disease unknown.

DUE TO

(B) Same

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-[illegible], 1949, *to* 6-26-, 1949 *that I last saw the deceased alive on* 6-25-, 1949 *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm H. Cargiles M.D.

23B. ADDRESS: 611-N. Caroline St

23C. DATE SIGNED: 6-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 1/49

24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem

24D. LOCATION (City, town, or county) (State): A.A. County Md

DATE RECEIVED BY LOCAL REGISTRAR: JUN 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm H.G. Elliott Jr

ADDRESS: 931 1129 N. Caroline St

CERTIFICATE CORRECTED 6-29-49 ✓491 X G75799

BIRTH NO. G75799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM E. FINNELL (djn)

2. DATE OF DEATH: June 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Waterloo
D. STREET ADDRESS (If rural, give location):

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 12, 1889
9. AGE (In years last birthday): 59 — If under 1 year: Months, Days; If under 1 hour: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter, Unemployed
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY: ✓

13. FATHER'S NAME: George William Finnell
14. MOTHER'S MAIDEN NAME: Virginia Hansucker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 226-12-4423
17. INFORMANT: Charles B. Finnell, Washington, D.C. — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 6-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 6/29/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Hebron
24D. LOCATION (City, town, or county) (State): Winchester, Va.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1217 St. Paul St.

107 ✓

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Important. Physician: please write the cause of death clearly and correct age is especially

CERTIFICATE CORRECTED 6-29-49 ✓ 1685 G75800

G75800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. BC 49-13005

1. NAME OF DECEASED (Type or Print) William Charles Baby Schwartz, Jr.

2. DATE OF DEATH 6/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-05

d. STREET ADDRESS (If rural, give location) 2211 W. Lafayette Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If years, last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Single	6/19/49			10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Schwartz	Eleanor Pitkivitz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		none	William C. Schwartz	2211 W. Lafayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		(INTERVAL BETWEEN ONSET AND DEATH)
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Purulent pericarditis & Septic meningitis.	(7)
	DUE TO (B) B. Coli Septicemia	4 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Prematurity 6. mo.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* June 29, 1949, *that I last saw the deceased alive on* June 29, 1949, *and that death occurred at* 5:50 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
F. N. Sherwin M. D.	St. Agnes Hospital	6-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	6/30/49	Prospect Hill	Towson Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	[illegible]	William Cole Inc	1217 E. Cold St

VS 150

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PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physician: please write the cause of death clearly and legibly.

G75801 ✓ X 16 G75801

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) JAMES LEONARD MC MANUS

2. DATE OF DEATH June 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Marine Hospital
Wyman Park Drive & 31st St.

c. Length of stay in Baltimore 16 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pa.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Philadelphia
D. STREET ADDRESS (If rural, give location) 152 Tree St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Wid.	10/22/83	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Deckhand	Seafarer	Pa.	USA

13. FATHER'S NAME: James Mc Manus

14. MOTHER'S MAIDEN NAME: Mary Sweeney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown	705-05-8410	Records-US Marine Hospital, Balto, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subphrenic abscess right, with rupture into right lung — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 13, 1949, *to* June 29, 1949 *that I last saw the deceased alive on* June 29, 1949, *and that death occurred at* 3:20AM, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M. D.	US Marine Hospital, Balto, Md.	6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Shamer	June 29/49	Philadelphia, Pa	Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 29 1949	Huntington Williams, M.D.	Austin E. Donovan	3818 Roland Ave.

Huntington Williams, M.D.

129

Please write the cause of death clearly and accurately. Physician: please write the exact age in especially important. Physician: please write the cause of death clearly and accurately.

G75802

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75802

Registered No.

1. NAME OF DECEASED (Type or Print) — Paul W. Stout

2. DATE OF DEATH — June 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — University Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — University Hospital

C. Length of stay in Baltimore — 2 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institutional: residence before admission)
A. STATE — Indiana
B. COUNTY — Tippecanoe
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Lafayette Indiana
D. STREET ADDRESS (If rural, give location) — Lafayette Indiana

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Feb-11-1911	38	7 / 18	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver	Express		

13. FATHER'S NAME — Mitchell Stout

14. MOTHER'S MAIDEN NAME — May Edwards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Unknown	Unknown	University Hospital	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Coronary Thrombosis — Interval between onset and death: 2 days
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 27, 1949, *to* June 29, 1949, *that I last saw the deceased alive on* June 29, 1949, *and that death occurred at* 1130P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert C. Hunter M.D.	University Hospital	6-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	6/29/49	Hyper-Stout Funeral Home	Lafayette Indiana

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Cutting for Williams, M.D.	Earl B. Houston	403 E. 25th St.

VS 150

940

G75803

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 43

G75803

Registered No.

1. NAME OF DECEASED (Type or Print) Jacob Stoler

2. DATE OF DEATH June 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

C. Length of stay in Baltimore 28 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-6
D. STREET ADDRESS (If rural, give location) 1803 E Lafayette Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	1892	57	-			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Grover Business		Lith	USA

13. FATHER'S NAME Nathan Stoler

14. MOTHER'S MAIDEN NAME Sarah Abramovitz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Isadore Stoler ADDRESS 2871 W Garrison Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vas Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 1949 *to* June 1949, *that I last saw the deceased alive on* June 28, 1949, *and that death occurred at* 1:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Samuel V. Tongrakow, M. D.	3600 Park Heights ave	June 29 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 30, 1949	Chizuk Amuno Cong	Reisterstown, Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams, MD	Sol Levinson & Bros	W North Ave 1126

VS 150

93D

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

AB-124864
75804

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

0 23

Registered No. G75804

BIRTH NO.

1. NAME OF DECEASED (Type or Print) B. Bedford Spicer

2. DATE OF DEATH June 28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 64yrs (Yrs. / Mon. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-6
D. STREET ADDRESS (If rural, give location) 3360 Chestnut Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Single	April 5- 1871	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Virginia	U S A

13. FATHER'S NAME: Benjamin Spicer

14. MOTHER'S MAIDEN NAME: Mary ~~Stellmeyer-or-Stellmyer~~ Santmeyers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No	219-01-8671A	Baltimore City Hospitals Record-4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

(B) Luetic Heart disease with pulmonary

DUE TO congestion

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-26-, 1948, *to* 6-28-, 1949 *that I last saw the deceased alive on* 6-28-, 1949, *and that death occurred at* 8.30Am, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. S. Rogers M. D.	Baltimore City Hospitals	6-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 30, 1949	St. Mary's (Hampden)	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JUN 30 1949	Huntington Williams, M.D.	Burgee Funeral Home 3631 Falls Road

VS 150

30E

RECORD WHITE FLORIDA, WITH UNFADING INK. Every item of information should be carefully supplied. Street age is especially important. Physicians: please write the cause of death clearly and legibly.

G75805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17 D

G75805 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth M. Knabe

2. DATE OF DEATH June 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Med. Wing 3

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 36 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-2
D. STREET ADDRESS (If rural, give location) 1667 Shadyside Road

5. SEX female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 8-9-98
9. AGE (If under 1 year last birthday) 50 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pa
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Grant Minier
14. MOTHER'S MAIDEN NAME Nellie Gorman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS
JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the breast — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-12-, 1949 *to* 6-29-, 19__, *that I last saw the deceased alive on* 6-29-, 1949, *and that death occurred at* 9:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 6-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 2 1949
24C. NAME OF CEMETERY OR CREMATORY New Cathedral
24D. LOCATION (City, town, or county) (State) Old Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR JUN 30 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR John C. Moran
ADDRESS 3600 E. Baltimore St

VS 150

50

Please write the cause of death clearly and legibly. Physician: please write the exact age as especially important. Every question must be answered. Entries must be made in ink.

G75806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

7620

G75806

BIRTH NO. B.C. 49-13046 Registered No.

1. NAME OF DECEASED (Type or Print) Baby Girl Honeman

2. DATE OF DEATH 6-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hosp
C. Length of stay in Baltimore Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto - 31
D. STREET ADDRESS (If rural, give location) 1235 Broadway 2-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	N.B	6-26-49			3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balto. Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Leroy Honeman	Kathryn Beane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Same	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Bilateral Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Atelectasis — 3 days

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT Hypertrophic Pyloric Obstruction

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-26, 1949 *to* 6-27, 1949, *that I last saw the deceased alive on* 6-29, 1949, *and that death occurred at* 4:35 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William R Gant M. D.	Church Home & Hosp	6-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 30/49	New Cathedral	Old Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams M.D.	J. Wade Moran	3006 Baltimore St

VS 150

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use typewriter if possible. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G75807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75807

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice Lewis

2. DATE OF DEATH: June 26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Balto. Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.
C. Length of stay in Baltimore: 25 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 904 W. Fayette St 18-1

5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: July 10-78
9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min.: 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Lancaster Co. Va
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Solmon Green
14. MOTHER'S MAIDEN NAME: Fannie Green
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Georgiana Daily ADDRESS: 1412 W Saratoga

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-sclerotic C. V. Disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Autopsy / Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Ruzer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 26 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6-30-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or County) (State): Baltimore Md
25. FUNERAL DIRECTOR: Elroy D. Wilson ADDRESS: 1201 Bentley St
DATE RECEIVED BY LOCAL REGISTRAR: JUN 30 1949
REGISTRAR'S SIGNATURE: [illegible]

VS 151

930

G75808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 31

G75808

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY Y. CARTER (djm)

2. DATE OF DEATH June 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4809 Laurel Avenue

27-17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Married	Apr. 26, 1878	71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman	Pickle Packers	Virginia	

13. FATHER'S NAME: Charles Carter

14. MOTHER'S MAIDEN NAME: Edna Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT — ADDRESS: Lillian M. Carter, 4809 Laurel Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage

DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR

23C. DATE SIGNED June 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/2/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 30 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1317 St. Paul St.

VS 151

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the cause of death clearly and correct age is especially important. Physician: please write legibly.

G75809

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

18

G75809

Registered No.

1. NAME OF DECEASED (Type or Print): Mary E. Goodwillie

2. DATE OF DEATH: JUN 28 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-1
D. STREET ADDRESS (If rural, give location): 205 Wendover Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	4-26-70	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Ohio	

13. FATHER'S NAME: Thomas Goodwillie

14. MOTHER'S MAIDEN NAME: Mary Barnett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the cause of death clearly and legibly. Physician please write correct age is especially important.

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Liver, carcinoma of, metastatic

DUE TO

(B) Carcinoma of kidney

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/25/49	Carcinoma of liver	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-14-, 1949 *to* 6-28-, 1949 *that I last saw the deceased alive on* 6-28-, 1949, *and that death occurred at* 6 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John B. Crow M. D.	JOHNS HOPKINS HOSPITAL	6/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 1, 1949	Lake View Cemetery	Cleveland, Ohio

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams M.D.	John O. Mitchell Sons	1900 Eutaw Place

VS 150

52a

G75810

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75810

Registered No.

1. NAME OF DECEASED (Type or Print) Elizabeth Washington

2. DATE OF DEATH June 27 19X9

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1315 N Carey St.

C. Length of stay in Baltimore 50 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1315 N Carey St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balto Md.
D. STREET ADDRESS (If rural, give location)
1315 N Carey St 15-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	W-Colored	?	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Md.	

13. FATHER'S NAME
John Turner

14. MOTHER'S MAIDEN NAME
Rebecca Hardy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT
William P. Reeder
ADDRESS
1919 Fulton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Disease — Unknown
DUE TO
(B) Cerebral Hemorrhage — 4 days
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 27, 19X9 *to* June 27, 19X9 *that I last saw the deceased alive on* June 27, 19X9, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. William Frey M. D.	1928 Penna ave	6/29/X9

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 2-1949	Mt Auburn	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	26. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams, MD	Wm Brooks	1463 N. Carey St

VS 150

93D

Write the cause of death clearly and legibly. Physician please write the correct age if especially important.

G75811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75811

BIRTH NO. B.C. 49-13100

1. NAME OF DECEASED (Type or Print): Baby Boy Fitze

2. DATE OF DEATH: 6/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Sinai Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 8-4
D. STREET ADDRESS (If rural, give location) 1222 N Bradford St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	—	6-28-49			33 / 15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joshua Arnold Fitze

14. MOTHER'S MAIDEN NAME: Myrtle Duff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT: J. Arnold Fitze ADDRESS: 1222 Bradford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 27, 1949, *to* June 29, 1949, *that I last saw the deceased alive on* June 29, 1949, *and that death occurred at* 11:30 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE Albert J. Weiss M. D.

23B. ADDRESS Sinai Hospital

23C. DATE SIGNED 29 June 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 6-30-49

24C. NAME OF CEMETERY OR CREMATORY Balto Cem

24D. LOCATION (City, town, or county) (State) Balto

DATE RECEIVED BY LOCAL REGISTRAR JUN 30 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jos. Hunt & Son ADDRESS 3201 Century Ave 1600

VS 150

Please write plainly, with ink. Underline cause of death clearly and legibly. Physician's signature is important. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G75812

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75812

Registered No.

1. NAME OF DECEASED (Type or Print): Ida M. Watson

2. DATE OF DEATH: June 28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1727 McKeans ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

c. Length of stay in Baltimore: 8 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1727 McKeans ave
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. md 15-2
D. STREET ADDRESS (If rural, give location): 1727 McKeans ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow	1873	75	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	none	Brooklyn a a. Co Md	U.S.A.

13. FATHER'S NAME: Richard Brooks

14. MOTHER'S MAIDEN NAME: Mary Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		William V. Brooks

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks

DUE TO

(B) Hypertension - Cardio-Vas-Ren Disease — ? —

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT:

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 20, 1949, *to* June 28, 1949, *that I last saw the deceased alive on* June 27, 1949 *and that death occurred at* 6 A m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. McDonald M. D.	844 N Carey Balt. Md	6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 1-49	Dorsets A.A. Co Md	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams, M.D.	James A. Hayes	1412 W. Fayette St

VS 150

121a

Physician: Please write the cause of death clearly and legibly. Exact age is especially important.

G75813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

G75813

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) M. DWIGHT BOVIS.

2. DATE OF DEATH June 28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 601 West 40th St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-7
D. STREET ADDRESS (If rural, give location) 601. West 40th Street.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Feb. 6-1883	66	4	22.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Secty & Treasurer

10B. KIND OF BUSINESS OR INDUSTRY L. Grief & Bros.

11. BIRTHPLACE (State or foreign country) Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Stephen Bovis -

14. MOTHER'S MAIDEN NAME Achsah White -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No.	No.	

17. INFORMANT ADDRESS Mrs. Cora B. Bovis - 601 W. 40th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Cecum -

DUE TO

(B) Metastatic Carcinomatosis, Abdominal

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2½ yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August 24 *to* June 28, 19 49 *that I last saw the deceased alive on* June 28 19 49 *and that death occurred at* 3:15 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Wm. Lundholm M. D.	Univ. Maryland Hosp.	June 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 1-1949	Loudon Park Cem.	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams, M.D.	Syfer Funeral Home	1600 W Baltimore

VS 150

46E

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75814 G75814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Ward 1

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) WALTER C. MILLER

2. DATE OF DEATH 6-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland ✓

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL.

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.

D. STREET ADDRESS (If rural, give location) 108 W. Saratoga St. 4-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	W	Widowed	Sept 1866	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Pennsylvania	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—		Walter H. Miller	2815 Riggs Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 4-6 hrs

DUE TO

(B) Generalized Arteriosclerosis — —

DUE TO

(C) — —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — —

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-28, 1949 *to* 6-28, 1949, *that I last saw the deceased alive on* 6-28, 1949, *and that death occurred at* 7:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. M. Swilson M. D.	Mercy Hosp	6-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 1 1949	Prospect Cem	Catonsville York Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams, M.D.	Mamie B. Syfer	1600 W. North Ave 94a

VS 150

Every item of information should be given if known. Please write the cause of death clearly and correct age is especially important. Physician: please write plainly.

G75815

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

585

G75815

Registered No.

1. NAME OF DECEASED (Type or Print) VIOLA BYCZYNSKI

2. DATE OF DEATH JUNE 29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 808 S. Glover st.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 58 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY BALTO
c. CITY OR TOWN BALTO (If outside corporate limits, write RURAL and give township) 1-4
D. STREET ADDRESS (If rural, give location) 808 S. GLOVER ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
FEMALE	WHITE	MARRIED	OCT 12/1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE	HOUSE WIFE	POLAND	USA

13. FATHER'S NAME JACOB PLUKOWSKI

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT JAMES BYCZYNSKI ADDRESS 808 S. Glover st.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronis vascular renal disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic cholecystitis — 2 yrs

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 1 1949 *to* June 29, 1949 *that I last saw the deceased alive on* June 28, 1949, *and that death occurred at* 8:45 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George D. Lisk M. D.	432 S. Bellevue St. Ave.	6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	July 2/49	ST. STANISLAUS CEM	DUNDALK AVE MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams, M.D.	STEPHEN J. FIALKOWSKI INC	1312 Wood Ave

VS 150

Note the cause of death clearly and legibly. Physician please write the correct age is especially important.

G75816

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75816

1. NAME OF DECEASED (Type or Print): ADELAIDE DANEKER

2. DATE OF DEATH: June 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3301 W. Strathmore Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3301 W. Strathmore Ave. 27-20

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	single	Dec. 20, 1863	85yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Stenographer		Baltimore, Md.	

13. FATHER'S NAME: John Fletcher Daneker

14. MOTHER'S MAIDEN NAME: Mary Carter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		none

17. INFORMANT: Mrs. Charles Wells ADDRESS: 3301 W. Strathmore Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis

DUE TO

(B) Chr. myocarditis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 25, 1949, to June 28, 1949, *that I last saw the deceased alive on* June 26, 1949, *and that death occurred at* 1.15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. E. Shannon M. D.	825 Medical Arts Bldg.	June 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/1/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

937

G75817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170.0

G75817

Registered No.

BIRTH NO. B.C. 49-12961

1. NAME OF DECEASED (Type or Print): BABY GIRL SMITH

2. DATE OF DEATH: 6/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BON SECOURS HOSPITAL
c. Length of stay in Baltimore: 17 HRS. 50 MIN. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-2
D. STREET ADDRESS (If rural, give location): 2117 W. Lexington St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year, last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	single	6/29/49				17	50

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James D. Smith

14. MOTHER'S MAIDEN NAME: Mary Peter Hardesick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: James D. Smith ADDRESS: 2117 W. Lexington St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ERYTHROBLASTOSIS FOETALIS — INTERVAL BETWEEN ONSET AND DEATH: 17 HRS 15 MIN

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/29, 1949 *to* 6/29, 1949, *that I last saw the deceased alive on* 6/29, 1949, *and that death occurred at* 10:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul D. Manning M. D.

23B. ADDRESS: BON SECOURS HOSP.

23C. DATE SIGNED: 6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): —

24B. DATE: June 30, 1949

24C. NAME OF CEMETERY OR CREMATORY: St. Peters

24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUN 30 1949

REGISTRAR'S SIGNATURE: Tuttington Williams, M.D.

25. FUNERAL DIRECTOR: George D. Farley ADDRESS: Fulton Ave & Fayette St.

VS 150

161c

Please write plainly, using ink. Entry of information should be complete. Every question must be answered. If unknown, write UNKNOWN in ink. Entry of the cause of death clearly and correct age is especially important. Physician, please write the

G75818

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153

G75818

Registered No.

1. NAME OF DECEASED (Type or Print) Bertha Clemmons

2. DATE OF DEATH 6-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1320 Myrtle Ave

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 17-3
D. STREET ADDRESS (If rural, give location) 1320 Myrtle Ave.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col.	Widow	Sept. 6, 1898	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Williamston N.C.	U.S.A.

13. FATHER'S NAME Henry Bell

14. MOTHER'S MAIDEN NAME Agnes Hill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT Esther Thompson ADDRESS 1320 Myrtle Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO

(B) Carcinoma of Cecum — 6 months

DUE TO

(C) Ca. Intest. Obstruction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-14-48	Ca of Cecum	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11/29/48, 19__, *to* June 28, 1949, *that I last saw the deceased alive on* June 28, 1949, *and that death occurred at* 3:0 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	2243 Madison Ave	6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-1-49	Rocky Mount N.C.	N.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	[signature]	Mrs Katie R Williams	329 E. Colonade St

VS 150

46E

G75819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75819

Registered No.

BIRTH NO. B.C. 49-12801

1. NAME OF DECEASED (Type or Print) Baby Boy LANARO — 76-0

2. DATE OF DEATH 24 June 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital Inc

c. Length of stay in Baltimore 3 ~~Yrs.~~ ~~Mos.~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits write RURAL and give township) Balto - (Walbrook)
D. STREET ADDRESS (If rural, give location) 3507 Clifton Ave 15-48

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	single	2 June 49		—	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) newborn

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Balto. Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John LANARO

14. MOTHER'S MAIDEN NAME Prodey Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Hospital Records Mercy Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Sclerema Neonatorum — 2 days

DUE TO

(B) Atelectasis — 1 day

DUE TO

(C) Respiratory Failure — 1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. —

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 21 June 19 49 *to* 24 June 19 49, *that I last saw the deceased alive on* 24 June 19 49 *and that death occurred at* 12:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE L. M. Bacon, M. D.

23B. ADDRESS Mercy Hospital

23C. DATE SIGNED 24 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify) -B-

24B. DATE 6-30-49

24C. NAME OF CEMETERY OR CREMATORY CATHEDRAL.

24D. LOCATION (City, town, or county) (State) CITY

DATE RECEIVED BY LOCAL REGISTRAR JUN 30 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS
WIEDEFELD & SON
GREENMOUNT AVE & 22ND 1612

VS 150

Please write in ink. Every item of information should be carefully supplied. Write the cause of death clearly and correct age is especially important. Physician: please write the

G75820 5390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3.1

G75820

Registered No.

BIRTH NO. BC.49.05-390

1. NAME OF DECEASED (Type or Print) Baby STephanie Pierzchalski

2. DATE OF DEATH 6/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-5
D. STREET ADDRESS (If rural, give location) 6425 Bunker St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH (Mo.)	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W		March 12, 1945		3	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Stephan Pierzchalski

14. MOTHER'S MAIDEN NAME Dolores Schenning

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

C. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intercurrent Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

(B) Arnold-Chiari Syndrome — since birth

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 23, 1949, *to* June 27, 1949 *that I last saw the deceased alive on* June 27, 1949, *and that death occurred at* 9.32 Pm., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John B. Shell M. D.	Mercy Hospital	6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	June 30. 1949	Holy Rosary	Trappe Road.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams M.D.	Wendell J. Rippel	812 S Broadway

VS 150

157D

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75821

JLB 128016

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163 Registered No. G75821

1. NAME OF DECEASED (Type or Print) Joseph Martinek

2. DATE OF DEATH 6-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore 2 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 612 N. Baltimore St. 4-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	March 26, 1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Whosale Fish Market	Md.	

13. FATHER'S NAME: Vincent Martinek

14. MOTHER'S MAIDEN NAME: Barbara Rytina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	None	?

17. INFORMANT: B. C. H. Records, ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

(Please write the cause of death clearly and correct age is especially important. Physician: please write the

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of lung

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 4-1-49, 19__, *to* June 28, 1949 *that I last saw the deceased alive on* June 28 1949 *and that death occurred at* 7.20 PM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. L. Bozarth M. D.	4940 Eastern Ave.	6-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/1/1949	Oak Hill	Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 30 1949	Huntington Williams, M.D.	Lilly & Zeiler Inc. 403 S. Wolfe Street

VS 150

47)

G75822 ✓ 72.0 G75822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Catherine Collins

2. DATE OF DEATH 6-29-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 405 S.Washington Street

c. Length of stay in Baltimore: Unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 405 S.Washington Street 2-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	1-15-1877	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Maryland	U.S.A.

13. FATHER'S NAME Andrew Mueller

14. MOTHER'S MAIDEN NAME Elizabeth Schoenals

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	None	None

17. INFORMANT: John J.Collins ADDRESS: 405 S.Washington St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2yrs.

DUE TO

(B) Chronic Arthritis — 6yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 26, 1946, *to* June 27, 1947, *that I last saw the deceased alive on* June 28, 1947, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John F. Fredericksen M. D.	1809 Eastern Ave	6-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-2-1949	Mount Carmel	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUN 30 1949	Huntington Williams, M.D.	Lilly & Zeiler Inc. 403 S.Wolfe Street

VS 150

93c

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75823

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Maggie Griffin

2. DATE OF DEATH June 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1720 Presbury st

c. Length of stay in Baltimore Yrs. 6 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto city
D. STREET ADDRESS (If rural, give location) 1720 Presbury st 15-2

5. SEX F | 6. COLOR OR RACE C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Aug 18, 1885 | 9. AGE (In years last birthday) 63 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME J. Cades

14. MOTHER'S MAIDEN NAME Caroline Burgers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Carrie Green ADDRESS 1826 Westwood ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular disease — INTERVAL BETWEEN ONSET AND DEATH 2 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 26, 1949 *to* June 27, 1949 *that I last saw the deceased alive on* June 27 1949 *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE Wilmer H. Watts M. D. | 23B. ADDRESS 1515 Linden Ave | 23C. DATE SIGNED 6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE June 30, 1949 | 24C. NAME OF CEMETERY OR CREMATORY Mt Zion cem. | 24D. LOCATION (City, town, or county) md (State)

DATE RECEIVED BY LOCAL REGISTRAR JUN 30 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR George E. Nelson ADDRESS 1303 Pennsylvania Ave

VS 150

93D

Please write the cause of death clearly and legibly. Physician please write the correct age if special important.

G75824 ✓ G75824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1 r 1

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY T. JOHNSON

2. DATE OF DEATH JUNE 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 441 WATTY CT., McCULLOH HOMES

C. Length of stay in Baltimore 40 YEARS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 11-24

D. STREET ADDRESS (If rural, give location) 441 WATTY CT., McCULLOH HOMES

5. SEX MALE

6. COLOR OR RACE NEGRO

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH JULY 6, 1894

9. AGE (In years last birthday) 54 yrs
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) EASTERN SHORE, MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES
(If yes, give war or dates of service) WW. I

16. SOCIAL SECURITY NO.

17. INFORMANT ROSA JOHNSON, ADDRESS 441 WATTY CT

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) aortic Insufficiency — INTERVAL BETWEEN ONSET AND DEATH 5 years
DUE TO arteriosclerosis ?
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-1- , 1949 *to* 6-28- ; 1949 *that I last saw the deceased alive on* 6-28- , 1949 *and that death occurred at* 7½ a.m., *from the causes and on the date stated above.*

23A. SIGNATURE LOUIS E. HARMON M. D.

23B. ADDRESS 2224 Madison Ave.

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE JULY 1, 1949

24C. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL

24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND

DATE RECEIVED BY LOCAL REGISTRAR JUN 30 1949

REGISTRAR'S SIGNATURE Washington Williams, M.D.

25. FUNERAL DIRECTOR Charles R Law

ADDRESS 802 Madison Ave

92a

VS 150

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

BIRTH NO. G75825

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75825

1. NAME OF DECEASED (Type or Print): WILLIAM FAHEY

2. DATE OF DEATH: June 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 700 Fleet Street
C. Length of stay in Baltimore: None (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 40 E. Hill Street 22-1

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1-28-1911
9. AGE (In years last birthday): 38 smt (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10B. KIND OF BUSINESS OR INDUSTRY: Airplane Plant
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Francis H. Fahey
14. MOTHER'S MAIDEN NAME: Margaret E. Burns
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes (If yes, give war or dates of service): World War # 1
16. SOCIAL SECURITY NO.
17. INFORMANT: Margaret Ellen Fahey (Mother) ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 6-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 1 / 49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross - Brooklyn
24D. LOCATION (City, town, or county) (State): Ritchie Highway

DATE RECEIVED BY LOCAL REGISTRAR: JUN 30 1949
REGISTRAR'S SIGNATURE: [illegible] M.D.
25. FUNERAL DIRECTOR ADDRESS: Krause Funeral Home 94a / 216 S. Charles St. 30

correct age is especially important. Physicians: please write the

G75826 — BALTIMORE CITY HEALTH DEPARTMENT — G75826

BIRTH NO. G75826

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ANNIE WATSON

2. DATE OF DEATH: June 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore Gen. Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3658 W. Montgomery Street 21-1

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH:
9. AGE (In years last birthday): About 57 — If under 1 Year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --
10B. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: --
14. MOTHER'S MAIDEN NAME: Janie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT — ADDRESS: Mrs. Ethel Jackson, 1520 William Street

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic cardiovascular disease	
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 6-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 6/30/49
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
24D. LOCATION (City, town, or county) (State): Anne Arundel, County, Maryland

DATE RECEIVED BY REGISTRAR: JUN 30 1949
REGISTRAR'S SIGNATURE: Tuttington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Wm. Cook, Inc., 1217 St. Paul Street

VS 151

93D

BIRTH NO. G75827

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1949

Registered No. G75827

1. NAME OF DECEASED (Type or Print): Mrs Elizabeth M. Rusk

2. DATE OF DEATH: 6/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 6 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-2
D. STREET ADDRESS (If rural, give location): 2907 Overland Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W		Jan. 11 1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Balto. Co Md.	

13. FATHER'S NAME: John Kearney
14. MOTHER'S MAIDEN NAME: Mary Dalton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lt. John D. Rusk - ADDRESS: 2907 Overland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Increased Cranial pressure
DUE TO
(B) Brain Tumor
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/28/49	Tumor in Rt Hemisphere	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 6/23, 1949, to 6/29, 1949, that I last saw the deceased alive on 6/29, 1949, and that death occurred at 12 P.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John F Benson M. D.	Un. Hosp.	6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	7-4-49	New Cathedral	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams, M.D.	Leonard J. Leuck	5305 Harford

54a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

G75828

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John M. Mulligan

2. DATE OF DEATH: 6/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jenkins Memorial Hospital

c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1027 Valley St 10-1

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	11/11/1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Clerk

10B. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Matthew Mulligan

14. MOTHER'S MAIDEN NAME: Annie Byrne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-11-4666

17. INFORMANT: Rita Mulligan ADDRESS: 1027 Valley St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

(B) Congestive heart failure

DUE TO

(C) Arteriosclerotic hypertensive CVD — ? yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Hemiplegia, left

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 25, 1949 *to* June 29, 1949 *that I last saw the deceased alive on* June 29, 1949 *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Herbert J. Landkas M. D.

23B. ADDRESS: St. Agnes Hospital

23C. DATE SIGNED: 6/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/2/49	New Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 30 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Rita Wiedefeld — ADDRESS: 900 E. Biddle St.

VS 150

93D

Please write the cause of death clearly and legibly. Physician's age is especially important.

G75829

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75829 Registered No.

1. NAME OF DECEASED (Type or Print): SUE M. SHERIN

2. DATE OF DEATH: June 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Haven Nursing Home 4515 Garrison Blvd.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3506 Clifton Ave. 15-48

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	widowed	Aug. 24, 1884	64 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	

13. FATHER'S NAME: Thadius Bryan

14. MOTHER'S MAIDEN NAME: Ann Weber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		no	Mr. Samuel B. Sherin	2629 Purnell Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Apoplexy
DUE TO
(B) arteriosclerosis
DUE TO
(C) Cardio-Vascular Disease Senility

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Sept 1st, 1948 to June 28 1949, that I last saw the deceased alive on June 28, 1949 and that death occurred at 11 P m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	3033 W North Ave	6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/1/49	Lorraine Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

93D

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75830

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Wilson, Mrs. May Lillian

2. DATE OF DEATH June 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 700 W. 40th St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home for Incurables

C. Length of stay in Baltimore Yrs. Life - 83 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) 700 W 40th St. 13-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Divorced -	Feb 13, 1866	83 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-	-	Balto - Md.	U.S.A.

13. FATHER'S NAME Robert Augustus Denny

14. MOTHER'S MAIDEN NAME Elizabeth Stuart.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	none	Mary E. Wharton. Home for Incurables

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

CERTIFICATE CORRECTED 2-18-49

G75831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. G75831

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Eleanora Wild (Eleanora Wilde)

2. DATE OF DEATH: 6/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctors Hospital

C. Length of stay in Baltimore: Life — Yrs. 6 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Middle River
D. STREET ADDRESS (If rural, give location): 1217 Fuselage ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Dec 19, 1879	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Keyser

14. MOTHER'S MAIDEN NAME: Louisa King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Phyllis S Cantwell ADDRESS: 1217 Fuselage Ave

MEDICAL CERTIFICATION

(Please write the cause of death clearly and fully. Physician: please write legibly. Correct age is especially important.)

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage, Spontaneous — Interval between onset and death: 4½ hours

DUE TO

(B) Hypertension and Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): no

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): no

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: — m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 31, 1949 *to* June 29, 1949, *that I last saw the deceased alive on* June 29, 1949, *and that death occurred at* 2:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jonas B Beck M.D. M. D.

23B. ADDRESS: 901 Fuselage Av. Baltimore 20 Md

23C. DATE SIGNED: June 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 2, 1949

24C. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery

24D. LOCATION (City, town, or county) (State): Annapolis, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 30 1949

REGISTRAR'S SIGNATURE: Evelington Williams, M.D.

25. FUNERAL DIRECTOR: Wallis Lamoreau

ADDRESS: 1003 W. Baltimore St.

VS 150

R.3a

G75832

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75832 Registered No.

1. NAME OF DECEASED (Type or Print) ~~Edward Grona~~ Edward F. Gronaw

2. DATE OF DEATH 6-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore 27-19
D. STREET ADDRESS (If rural, give location) 5526 ~~Gist Ave~~ St. Charles Ave.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hosp.

c. Length of stay in Baltimore Yrs. Life Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married.	Feb. 13. 1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Self	Baltimore Maryland.	

13. FATHER'S NAME
Edward F. Gronaw

14. MOTHER'S MAIDEN NAME
Theresa Gore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	217-09-0304	Mrs. Augusta A. Gronaw, 5526 St. Charles Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia
DUE TO
(B) Hydronephrosis
DUE TO
(C) Bilateral Renal Calculi

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/29 *1949 to* 6/30, 1949, *that I last saw the deceased alive on* 6/30, 19 49 *and that death occurred at* 2:50 P *m., from the causes and on the date stated above.*

23A. SIGNATURE G. Fiel Harkins, Jr. M. D. | 23B. ADDRESS Franklin Sq. Hosp. | 23C. DATE SIGNED 6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 2, 1949	Mt. Olive Cemetery	Randallstown, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 30 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: J. Miles Lamotray | ADDRESS 4510 Liberty Heights Ave.

134a

Please write clearly and legibly. Physician: please write the cause of death clearly and correct age is especially important.

G75833

M M. 98816

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43

G75833

Registered No.

Use write the cause of death clearly and correct age is especially important. Physicians: please write plainly.

1. NAME OF DECEASED (Type or Print) Henry ,Heiger.

2. DATE OF DEATH June 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave,

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-4
D. STREET ADDRESS (If rural, give location) 2179 N. High ST. 9147, Broadway

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov.16, 1866
9. AGE (In years last birthday): 82 yrs (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob (DEC)
14. MOTHER'S MAIDEN NAME: Louise Porseinger. (DEC)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: B.C.H. Records ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypertensive cardiovascular disease	years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Generalized arteriosclerosis-advanced	years
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Thrombosis of right femoral artery	2 days

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-25- , 1946 *to* 6-28 , 1949, *that I last saw the deceased alive on* 6-28- , 1949 *and that death occurred at* 6.25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE C. S. Cozzens M. D.
23B. ADDRESS B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED 6-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/1/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): North Ave & Rose St.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 30 1949
REGISTRAR'S SIGNATURE: Temporary for Williams, M.D.
25. FUNERAL DIRECTOR: Clarence F.Hoffmann ADDRESS: 1639 Broadway.

VS 150

937

G75834

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

G75834

Registered No.

1. NAME OF DECEASED (Type or Print): Louise M. Henritze

2. DATE OF DEATH: 6/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4117 Granite Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-34
D. STREET ADDRESS (If rural, give location): 4117 Granite Avenue

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 6, 1883
9. AGE (In years last birthday): 65
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Christian Thomas

14. MOTHER'S MAIDEN NAME: Louisa Lowman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Howard L. Henritze — ADDRESS: 4117 Granite Ave

MEDICAL CERTIFICATION

(Please write the cause of death clearly and correct age is especially important. Physician: please

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B) Hypertensive Cardiovascular Disease many yrs.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August, 1947, *to* June 29, 1949, *that I last saw the deceased alive on* June 29, 1949, *and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Maf R. English M. D.
23B. ADDRESS: 5713 Belvidere
23C. DATE SIGNED: 6-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/2/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cem.
24D. LOCATION (City, town, or county) (State): Belvidere Rd - Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: John C. Miller Inc.
ADDRESS: 2435 E. Oliver St

VS 150

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G75835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No.

G75835

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY FLORENCE McLAUGHLIN

2. DATE OF DEATH: June 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1010 Poplar Grove St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1010 Poplar Grove St. 16-07

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: July 8, 1869
9. AGE (In years last birthday): 79 yrs. — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Patrick McLaughlin
14. MOTHER'S MAIDEN NAME: Emily Miles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Miss Marie A. McLaughlin — ADDRESS: 1010 Poplar Grove St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive + Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr +

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 1948 *to* 6/29, 1949, *that I last saw the deceased alive on* 6/29, 1949, *and that death occurred at* 9.45 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 3629 Edmondson Ave - 39
23C. DATE SIGNED: 6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/1/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

931

correct age is especially important. Physician: please write the cause of death clearly and legibly.

581.0 ✓ X

156.1

G75836

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75836

1. NAME OF DECEASED (Type or Print): Dell Glover

2. DATE OF DEATH: June 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Maternity

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 43 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Florida B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Tampa

D. STREET ADDRESS (If rural, give location): 313 W. Ida St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white		8-31-02	46				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst Foreman

10B. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): No. Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Glover

14. MOTHER'S MAIDEN NAME: Rhoda Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) ? Cirrhosis of Liver	1 yr.
ANTECEDENT CAUSES	DUE TO (B) ? bronchitis, ? malignancy	over
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: May 1949

19B. MAJOR FINDINGS OF OPERATION: alive

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/13/49 *to* 6/30/49, *that I last saw the deceased alive on* 6/30/49, *and that death occurred at* 9 a m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 6/30/1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 6/30/1949

24C. NAME OF CEMETERY OR CREMATORY: Wilson Funeral Home

24D. LOCATION (City, town, or county) (State): Jacksonville, Fla.

DATE RECEIVED BY LOCAL REGISTRAR: JUN 30 1949

REGISTRAR'S SIGNATURE: Tunstall for Williams, MD

25. FUNERAL DIRECTOR: Earl B. Preston ADDRESS: 403 E. 25th St

VS 150

124 B

Note the cause of death clearly and legibly. Physician, please write the correct age is especially important.

G75837 G75837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Florence Fresne

2. DATE OF DEATH June 29/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE W. Va. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Masa

D. STREET ADDRESS (If rural, give location) Box 158

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	1-20-81	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Italy	

13. FATHER'S NAME Joseph Chimacchi

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage, G-I, multiple, sec. to

DUE TO

(B) Panhemetacytopenia, cause undetm.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-11 1949 *to* 6-29, 1949 *that I last saw the deceased alive on* 6-29, 1949, *and that death occurred at* 3 27 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Norman E. Shaver M. D.	JOHNS HOPKINS HOSPITAL	6-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/2/49	East Oak Grove	Morgantown W. Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St Paul St.

72a

Please write the cause of death clearly and legibly. Physician please note that age is especially important.

JL- 122764 G75838 355 ✓

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75838

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Virginia Greenwood ,or Regina Newton

2. DATE OF DEATH: 6-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore ? Yrs. ? Mos. ? Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-12
D. STREET ADDRESS (If rural, give location): Balto. City Hosp. Infirmary

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Negro	Widow	Aug. ? ?	60 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Newton	Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		B. C. H. Records,	4940 Eastern Ave.

MEDICAL CERTIFICATION

Write the cause of death clearly and correct age is especially important. Physician: please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolism
DUE TO
(B) Thrombophlebitis of the Iliac veins
DUE TO
(C) Parenchymatous cortical cerebellar atrophy

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? yes ☒ no ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-7-48, 19—, *to* June 28, 1949, *that I last saw the deceased alive on* June 28, 1949, *and that death occurred at* 9.50AM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. L. Rosen M. D.	4940 Eastern Ave.	6-30-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	7-2-49	Ft Oak Grove Cem.	Washington D. C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUN 30 1949	Huntington Williams, M.D.	Mrs Kate R. Wilkins	32 Lafayette Ave

Vs 150

100 B

BIRTH NO. 175839

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75839

1. NAME OF DECEASED (Type or Print): J. Calvin Yeatter (Yeater)

2. DATE OF DEATH: 30 June 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital (DOA)
c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington D.C.
D. STREET ADDRESS (If rural, give location): 114 V. St. N.E.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 13 1880
9. AGE (In years last birthday): 69 — If under 1 Year: Months 2, Days 17; If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Solomon Yeater
14. MOTHER'S MAIDEN NAME: Suzanna Phillips
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Olive P. Yeater ADDRESS: 114 V St. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio-Vascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 30 June 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 2, 1949
24C. NAME OF CEMETERY OR CREMATORY: Wash. D.C.
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: S. H. Hines Co. ADDRESS: Washington, D.C.

VS 151
JUN 30 1949

937

Correct age in especially important. Physician: please write the cause of death clearly and legibly.

G758-40

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G758-40
Registered No.

1. NAME OF DECEASED (Type or Print): William J. Brady

2. DATE OF DEATH: June 27, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 4-2
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 731 W. Lexington

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widower	May 17, 1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	House	Baltimore, Md.	

13. FATHER'S NAME: Frederick Brady

14. MOTHER'S MAIDEN NAME: Rose Hipson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: John L. Brady. ADDRESS: 708 W. Lexington St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		INTERVAL BETWEEN ONSET AND DEATH
	(A) Pulmonary Tuberculosis	
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
William J. McCafferty M.D.		June 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/1/49	Meadow Ridge Memorial	Dorsey, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 1 1949	Huntington Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 151

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

13B

075841 Ac. 49-13932 BALTIMORE CITY HEALTH DEPARTMENT 5 075841

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Baby girl MILLER
2. DATE OF DEATH: 6-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Maryland Hospital
C. Length of stay in Baltimore: Yrs. Newborn Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1213 Winchester St. 16-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Femal	Colored		6-23-49		—	—	—	5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	University Maryland Hospital	U.S.A.

13. FATHER'S NAME: WALTER MILLER
14. MOTHER'S MAIDEN NAME: VIRGINIA Deboah William

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT: Mother — ADDRESS:

MEDICAL CERTIFICATION

Complete the cause of death clearly and fully. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Atelectasis — DUE TO
(B) Prematurity — DUE TO
(C) The Mother's severe Hypertension with a Super-imposed Pre-eclampsia necessitated the interruption of the Pregnancy at this time by Hysterotomy.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Lived 5 Minute

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
—	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 11:53 Am 6-23 1949 *to* 11:58 Am 6-23 1949 *that I last saw the deceased alive on* 6-23-49 19___ *and that death occurred at* 11:58 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. E. Covey Jr. M. D.	University Md. Hospital	6-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
—	—	UNIVERSITY MEDICAL SCHOOL JUN 29 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, MD	Commissioner of Health	

VS 150

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G75842 B.O. 49-13798 G75842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Baby Boy Carr

2. DATE OF DEATH 6-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore 5 ma. ~~Yrs.~~ ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14e3

D. STREET ADDRESS (If rural, give location) 2140 Druid Hill ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C		6-28-49				5	0

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	—	Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nathaniel Carr	Helen Viola Bowen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mother	

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) atelectasis

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-28- 19 49 *to* 6-28- 19 49, *that I last saw the deceased alive on* 6-28- 19 49, *and that death occurred at* 3:25 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. A. Thermann M. D.	Univ. Hosp.	6-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	JUN 2 91949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

159

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C.H.-12867 — Registered No. G75843

1. NAME OF DECEASED (Type or Print): Mary Louise Strong

2. DATE OF DEATH: 6/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 634 Washington Blvd.
c. Length of stay in Baltimore: Yrs. — Mos. 1 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 22-2
D. STREET ADDRESS (If rural, give location): 634 Washington Blvd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	S.	6/28/49			20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Balto.	USA

13. FATHER'S NAME: Charles Hudson Strong

14. MOTHER'S MAIDEN NAME: Mary Frances Vanorsdale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	—	Charles & Mary Strong - Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphixia

DUE TO

(B) aspiration of foreign material & resulting atelectasis.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
accident	home	

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
6/28/49 9P m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	

22. *I hereby certify that I attended the deceased from* 6/25, 1949, *to* 6/28, 1949, *that I last saw the deceased alive on* 6/28, 1949, *and that death occurred at* 9P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Haught M. D.	University Hosp.	6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
City Disp.		[illegible] MEDICAL SCHOOL JUN 29 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	Commissioner of Health	

V$ 150

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

161a

G758:4

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G758:4

Registered No.

1. NAME OF DECEASED (Type or Print): SARAH SINSKEY

2. DATE OF DEATH: JUNE 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTO. MD

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3203 BRIGHTWOOD RD WAYNE NURSING HOME

c. Length of stay in Baltimore: 75 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: BALTO.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 12-1
D. STREET ADDRESS (If rural, give location): ESPLANADE APTS - EUTAW PL. + LAKE DR.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	WIDOW		91		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WORK		RUSSIA	U.S.A.

13. FATHER'S NAME: NOT KNOWN

14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		RAYMOND SINSKEY	BALTO. MD

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician's please write the cause of death clearly and legibly. Physician's please write the cause of death clearly and legibly. Physician's

BIRTH NO. 73845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75845

1. NAME OF DECEASED (Type or Print): FRIEDA MERR — N-808.0

2. DATE OF DEATH: June 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. Gen. Hospital.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 1551 Clifton Avenue 13-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow		49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Solomon Roscoe
14. MOTHER'S MAIDEN NAME: Jennie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Stanley Merr — ADDRESS: 3728 Cottage Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Crushed chest.
DUE TO
(B) Ruptured diaphragm. Fractured pelvis. Compound fracture of left leg. Fractured right wrist.
DUE TO
(C) Atelectasis of left lung. Multiple abrasions and lacerations.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Park Heights Ave. & Springhill Ave.
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: June 29, 1949 4:35 p. m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCoccur? Ped. struck by auto. 15/12

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-1-49
24C. NAME OF CEMETERY OR CREMATORY: Balto. Hebrew
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 151

170 C

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75846

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY WILLIAMS

2. DATE OF DEATH June 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
320 North Gilmore Street

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 320 North Gilmore Street 19-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	colored			39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pulmonary Embolus	
	DUE TO	
ANTECEDENT CAUSES	(B) Aneurysm Aorta	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
William J. McDaffarty M.D.		June 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL JUN 27 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. [illegible]	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 151

30D

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G75847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75847

BIRTH NO.

1. NAME OF DECEASED (Type or Print) OLIVER LONEY

2. DATE OF DEATH June 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Ohio
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dayton
D. STREET ADDRESS (If rural, give location) 28 Gerard Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white			61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Emphysema, pulmonary

DUE TO

(B) Acute alcoholism

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED June 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	JUN 27 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. [illegible]	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	COMMISSIONER OF HEALTH	

VS 151

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Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

BIRTH NO. 75848

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 G75848 Registered No.

1. NAME OF DECEASED (Type or Print): HARRY A. MUDGE

2. DATE OF DEATH: June 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4409 Wentworth Rd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4409 Wentworth Rd. 28-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	white	single	Oct. 13, 1876	72 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired Office Mgr.	Wholesale Rubber	Baltimore, Md.	

13. FATHER'S NAME: George

14. MOTHER'S MAIDEN NAME: Cora Teal

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Miss Helen M. Sullivan ADDRESS: 4409 Wentworth Rd.

MEDICAL CERTIFICATION

Complete the cause of death clearly and correctly. Physician: please write the age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
DUE TO
(B) Cerebral Hemorrhage — 5 yrs.
DUE TO
(C) Arterio - Sclerosis (Generalized) — 10 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1949, *to* June 29, 1949 *that I last saw the deceased alive on* June 5, 1949, *and that death occurred at* 7A m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
Earl L. Chambers	4705 Liberty Hts. Ave	6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/1/49	Cathedral Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS. 150

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G75849 FGN 127272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75849 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Eleanor Elbert

2. DATE OF DEATH June, 10, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave,

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) No Home-Baltimore City Hospitals (Infirmary)

26-12

5. SEX Female
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH June, 30, 1876
9. AGE (In years last birthday) 72 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Langley (Deceased)
14. MOTHER'S MAIDEN NAME Elizabeth Custer (Deceased)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S ADDRESS Baltimore City Hospitals Records- 4940 Eastern Ave,

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

16. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction — 10 HRS.
DUE TO
(B) Arteriosclerotic Heart Disease — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) C
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 3, 1949, *to* June, 10, 1949, *that I last saw the deceased alive on* June, 10, 1949, *and that death occurred at* 1:40 p m., *from the causes and on the date stated above.*

23A. SIGNATURE T. S. Rogers M. D.
23B. ADDRESS Baltimore City Hospitals
23C. DATE SIGNED 6- 12- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL JUN 21 1949
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 1 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Commissioner of Health
ADDRESS

Vs 150

correct age is especially important. Physicians: please write or type the cause of death clearly and legibly.

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G75850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75850

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN SIMMS

2. DATE OF DEATH June 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Mercy Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 4-1
D. STREET ADDRESS (If rural, give location) 212 Colborne Street N. Calvert St.

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Unknown
8. DATE OF BIRTH Unknwon
9. AGE (In years last birthday) 63
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown
16. SOCIAL SECURITY NO.
17. INFORMANT Unknown ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteio-sclerotic P. V. Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

I DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED June 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY [illegible] MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State) JUN 30 1949

DATE RECEIVED BY LOCAL REGISTRAR JUL 1 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR [illegible] Commissioner of Health
ADDRESS

VS 15

931

G75851

BIRTH NO

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3-2-1 G75851 Registered No.

1. NAME OF DECEASED (Type or Print): Albert Roland Price

2. DATE OF DEATH: June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Uni ersity

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
4-2
D. STREET ADDRESS (If rural, give location): Found on lot at Fremont Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Unknown	Unknown	55				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknwon

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Unknown ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Alcoholism
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: June 22, 194

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE: 7-7-49

24C. NAME OF CEMETERY OR CREMATORY: Bal Co. Nat [illegible] JUN 2 0 1949

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JUL 1 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: [illegible] ADDRESS: Ellsworth Armacost

VS 151

I certify age is especially important. Physician: please write the cause of death clearly and legibly.

77D

G75852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 3 G75852

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jan Hendrick Biderick

2. DATE OF DEATH June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2-3
D. STREET ADDRESS (If rural, give location) 822 S. Broadway (Anchorage Hotel)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		Unknown	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Holland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT Unknown ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Epilepsy

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

Autopsy, Inspection or Inquiry

23A. SIGNATURE Emil Bogen M.D.

23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED June 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL JUN 3 01949

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 1 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

24. FUNERAL DIRECTOR Commissioner of Health

ADDRESS

VS 151

Please write the cause of death clearly and legibly. Physician: please write the exact age if especially important:

G75853
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 98 1.6 G75853
Registered No.

N 961.4

1. NAME OF DECEASED (Type or Print): Tommy Covington
2. DATE OF DEATH: June 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 400 Wilson St. 14-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
C	M	Married	Unknown	39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown		Unknown	

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown		Unknown	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bullet-wound of heart and lungs
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Restaurant	1305 Pennsylvania Ave.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
June 26, 1949 1P. m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
Thos H. Merrill M.D.		June 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	7-4-49	Mt. Calvary Cem.	[illegible] MEDICAL SCHOOL JUN 30 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	[illegible]	A. Halstead

VS 151

166

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G758:54

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 4 1

G758:54 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (DRURY) DRUREY (SAUNDERS) SANDERS (DJR) 2. DATE OF DEATH June 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 512 W. 28th Street

9-4

5. SEX	6. COLOR OR RACE	7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	9/25/1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Roofer	BUILDING	Balto. Md	

13. FATHER'S NAME
Drurey Sanders

14. MOTHER'S MAIDEN NAME
Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Francis Sanders	3508 Clifton Ave

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pneumococcic meningitis.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		6-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 1st 1949	Pine Grove U.B. Church	Parkton Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 151

8/a

Please write the cause of death clearly and correct age is especially important. Physician:

G75855

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75855

1. NAME OF DECEASED (Type or Print) BENJAMIN BANKS

2. DATE OF DEATH 7-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Levindale Home

C. Length of stay in Baltimore 38 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 27-17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Married	1888	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	none	Russia	USA

13. FATHER'S NAME: Unkown

14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
?		

17. INFORMANT: Mrs Lottie Barr — ADDRESS: 3518 Overview Road

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician please write the exact age if important.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma pancreas — Interval between onset and death: 1 year

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Diabetes mellitus — Interval between onset and death: several years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-3 19 49 *to* 7-1 19 49 *that I last saw the deceased alive on* 7-1 19 49 *and that death occurred at* 5 15 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Nagel M. D.	Levindale Home	7-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 1, 1949	Hebrew Rosedale Cemetery	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	Sol Levinson & Bros	1126 W North Ave

VS 150

469

G758:56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49 6 G758:56 Registered No.

BIRTH NO. BC-49-12733

1. NAME OF DECEASED (Type or Print) Baby Girl Bortner

2. DATE OF DEATH June 30, '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4527 Keswick Rd. 27-14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White		6-22-49			8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME Daniel Bortner

14. MOTHER'S MAIDEN NAME Rose Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Prematurity	
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 22, 1949 *to* June 30, 1949 *that I last saw the deceased alive on* June 30 1949, *and that death occurred at* 1:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hulton Ventcourt M. D.	JOHNS HOPKINS HOSPITAL	6-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 1-1949	Woodlawn	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

159

Please write the cause of death clearly and legibly. Physician's please write the cause of death clearly and legibly. Physicians please write the cause of death clearly and legibly. Physicians please write the cause of death clearly and legibly. Physicians

G758:57

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G758:57

1. NAME OF DECEASED (Type or Print) JAMES KELSON

2. DATE OF DEATH June 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Franklin Square Hospital

c. Length of stay in Baltimore 30 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 17 Norris St 19-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
male	colored			68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Farmville Va

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John Kelson

14. MOTHER'S MAIDEN NAME Eliz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Esther Kelson (D.) ADDRESS 17 Norris St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial degeneration

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED June 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried

24B. DATE 7/1/49

24C. NAME OF CEMETERY OR CREMATORY Loudon Park

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 1 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Thos H Kelly

ADDRESS 514 Cantrell Ave

937

VS 151

Please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75858

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 G75858 Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Margaret Mary Winterling

2. DATE OF DEATH: June 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: 62 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Rosedale
D. STREET ADDRESS (If rural, give location): Mt. Hoya Post Office Gibson Island

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	married	May 30, 1887	62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	—	Baltimore, Md	

13. FATHER'S NAME: John Schroefer

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT: Geo. C. Winterling ADDRESS: Gelston Ave. Rosedale Md

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery occlusion — Interval between onset and death: 2 weeks

DUE TO

(B) Hypertensive and arteriosclerotic cardio-vascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Obesity

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 29, 1949 *to* June 29, 1949 *that I last saw the deceased alive on* June 29, 1949 *and that death occurred at* 10:45 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. Andrew Alecci, M. D.	St. Joseph's Hospital	6-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-2-49	Sacred Heart	Gorman Mill Rd Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	Charles S. Zeiler	901 S Conkling St.

VS 150

93D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

Registered No. 6758:59

6758:59
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mr. William Adam Wolf

2. DATE OF DEATH June 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-3

c. Length of stay in Baltimore: Yrs. life Mos. Days

D. STREET ADDRESS (If rural, give location) 704 N. Bradford Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	May 8, 1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Fire Dept.	Baltimore, Maryland	

13. FATHER'S NAME: Adam Wolf

14. MOTHER'S MAIDEN NAME: Emma Fischer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Elizabeth Wolf	704 N. Bradford St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular accident

DUE TO

(B) Hypertensive cardiovascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic bronchitis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 28, 19 49, *to* June 30, 19 49, *that I last saw the deceased alive on* June 30, 19 49, *and that death occurred at* 8:10 *A.* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. Andrew Acree, M. D.	St Joseph's Hospital	6-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/4/49	Holy Redeemer Cem.	4430 Belair Rd. Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.

ADDRESS: 2601-3-5 E. Madison Street

VS 150

93D

BIRTH NO. 675860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 675860

1. NAME OF DECEASED (Type or Print): FELIX B. CLARK

2. DATE OF DEATH: June 27, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 522 N. Schroder St.

c. Length of stay in Baltimore: Visiting (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Michigan
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Detroit
D. STREET ADDRESS (If rural, give location): Visiting 522 N. Schroder St. Balto. Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. If under 1 year, Months; if under 1 day, Days; if under 1 hour, Min.)
M	C	Married	July 20. 1907	41

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector

10B. KIND OF BUSINESS OR INDUSTRY: Ford Plant

11. BIRTHPLACE (State or foreign country): Norfolk Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George B. Clarke

14. MOTHER'S MAIDEN NAME: Grace Bond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unkown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Vivian Smith ADDRESS: 522 N. Schroder St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular disease.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: June 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 1. 1949

24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State): Arbutus Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 1 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1000 Brantly Ave.

VS 151

93

Medical Examiner's Case released

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75861 — BIRTH NO.

9.3.5

G75861 — Registered No.

1. NAME OF DECEASED (Type or Print): Edward Lincoln Harp, Sr.

2. DATE OF DEATH: June 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR (If not in hospital or institution, give street address or location): St. Joseph's
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1611 East 30th — 9-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	Widowed	Dec. 3, 1862	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Insurance Co.	Baltimore	USA

13. FATHER'S NAME: Edward Harp

14. MOTHER'S MAIDEN NAME: Mary Shaw

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	none	1611 E. 30th. Street - 18 Mr. Edward L. Harp, Jr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-macular accident — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Intertrochanteric fracture - rt. hip.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

J. G. Merrill M. D.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If outside city, give exact location)
Accident Fracture, rt. hip	on street	Balto. City 9/6

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
March 20, 1949 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Dog jumped on him; he sat down heavily.

22. *I hereby certify that I attended the deceased from* March 20, 1949 *to* June 28, 1949 *that I last saw the deceased alive on* June 28, 1949 *and that death occurred at* 6:29 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William D. Roelofs, M. D.	1400 N. Caroline St.	June 28, 19

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/2/49	Greenmount Cemetery	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 1 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC. BALTIMORE - 13, MARYLAND

VS 150

Please write the cause of death clearly and correct age is especially important. - Physician:

186a

75862

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5-4-G75862

Registered No.

1. NAME OF DECEASED (Type or Print) SISTER MARY BASIL MURPHY.R.S.M.

2. DATE OF DEATH June 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt.St. Agnes Convent

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-15

D. STREET ADDRESS (If rural, give location) Smith Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	Aug.8,1869	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Religious			

13. FATHER'S NAME
Patrick Murphy

14. MOTHER'S MAIDEN NAME
Margaret Tierney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Mt. St. Agnes Convent ADDRESS
Sr.Mary Edith. Mt. Washington, Md

MEDICAL CERTIFICATION

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Carcinoma of Rectum
DUE TO
(B) Senility
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH
1½ yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1949, to 30 June, 1949 *that I last saw the deceased alive on* June 15, 1949 *and that death occurred at* 11.45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. Edwin Muller M. D.	2 in Read ST Baltimore Md	30 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/2/49	Mt.St.Agnes Convent Cem.	Mt. Washington, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 1 1949	Huntington Williams, M.D.	H.H. Mears and Son 805 N. Calvert St.

VS 150

46D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 675863

BIRTH NO. 175863

1. NAME OF DECEASED (Type or Print) TRACEY, JAMES Harvey

2. DATE OF DEATH 6-29-49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balt.
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 27-18
D. STREET ADDRESS (If rural, give location) 4938 Park Heights Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year Months Days	If under 24 hours Hours Min.
M	W	M	Oct 28 1914	35		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cab Driver	Cab Co	Md.	

13. FATHER'S NAME Wm E

14. MOTHER'S MAIDEN NAME Mary White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown	213-12-4034	Mary Tracey	4938 Park Heights Ave

MEDICAL CERTIFICATION

Write the cause of death clearly and correct age is especially important. Physician: please write this

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Embolism — few min
DUE TO
(B) Thrombophlebitis — few days
(C) Gangrene Ischemic — 14 days

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DM T.B. & Thrombophlebitis — 12 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-16-49	Gangrene Ischemic, pericystphlebitis	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-16, 1949, *to* 6-29, 1949, *that I last saw the deceased alive on* 6-29, 1949, *and that death occurred at* 6 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph B. Schenck M. D.	Franklin Sq. Hosp.	6-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 2/49	Druid Ridge	Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	Laning Byers	500 Park Ave

VS 150

127a

G75864

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 9-9 G75864 Registered No.

1. NAME OF DECEASED (Type or Print): WALLACE GARDNER — 11-990.1

2. DATE OF DEATH: June 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: 14 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 McCullogh Street 14-3

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Dec. 6, 1934
9. AGE (In years last birthday): 14 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mervin A. Gardner
14. MOTHER'S MAIDEN NAME: Irene Logan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Irene L. Gardner ADDRESS 2216 McCulloh St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Drowning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Park
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Druid Hill Park—Old sea lion pool
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 29, 1949 ?p.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Drowned while swimming 13/4

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: George A. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 6-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/2/1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Membrial Pk.
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 151

183

Correct age is especially important. Physician: please write the cause of death clearly and fully.

675865

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

675865

Registered No.

1. NAME OF DECEASED (Type or Print) James H. Johnson

2. DATE OF DEATH 29 June 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2412 Pennsylvania Ave.
c. Length of stay in Baltimore 73 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-1
d. STREET ADDRESS (If rural, give location) 2412 Pennsylvania Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	married	Oct. 1, 1875	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Boiler		Baltimore, Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Grace Johnson	Grace Howard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mrs. Grace Johnson	2412 Penna. Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic Cardio-Vascular Disease	
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23a. SIGNATURE	23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23c. DATE SIGNED
Wm. H. Kammer Jr. M.D.		29 June 1949

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/2/1949	Arbutus Mem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave. 939

VS 151

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

G75866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75866

Registered No.

BIRTH NO. B.C. #94242

1. NAME OF DECEASED (Type or Print) Thomas Kane

2. DATE OF DEATH 6-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore 23 Mos. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Balto

C. CITY, OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-2

D. STREET ADDRESS (If rural, give location) 518 N. Lakewood Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W	S	7-17-1948	0 1	11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Kane

14. MOTHER'S MAIDEN NAME Ethel Lockhart.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

Please write the cause of death clearly and accurately. Physician: please write the exact age is especially important.

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculous Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 10 wks

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-22-49	Deceased Intracranial Pressure	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-25-, 19 49, *to* 6-29-, 19 49, *that I last saw the deceased alive on* 6-29-1949, *and that death occurred at* 9:10 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. D. Thomas Jr. M. D.	Mercy Hosp	6-29

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	July 1/49	Schwartz & Sons	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	Philip Henrich Sons	2024 Eastern Ave

VS 150

14

75867 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 75867

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James R. Hand — 2. DATE OF DEATH: June 30th 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland — b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital DOA

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE MD B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — D. STREET ADDRESS (If rural, give location): 112 W. 25th St 12-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	Dec 20/88	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Theatre Operator	Amusement	Baltimore	

13. FATHER'S NAME: James H. Hand

14. MOTHER'S MAIDEN NAME: Emma R. Lancaster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Mrs. Nora B. Richardson — ADDRESS 112 W. 25th

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* _____ (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
William S. Helfrich M.D.		June 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 2/49	Baltimore	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	Philip Henry Sons, Eutaw St	94a

VS 151

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

BIRTH NO. 58118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 90 r. 0

Registered No. 58118

N-803.0

1. NAME OF DECEASED (Type or Print) EDDIE TAYLOR

2. DATE OF DEATH June 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1335 Pennsylvania Avenue 17-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	Widowed	1903	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Va	

13. FATHER'S NAME William Taylor

14. MOTHER'S MAIDEN NAME agnes Blackwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	221-05-2635		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1335 Pennsylvania Avenue 17-2

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) June 29, 1949 1.45 a.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Rolled off roof while sleeping

22. *I certify that I took charge of the remains described above, held an* Autopsy / Inspection / Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED June 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 4 1949	McKenney Va	McKenney Va

DATE RECEIVED BY LOCAL REGISTRAR JUL 1 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Geo. E. Kelson ADDRESS 1303 Pennsylvania Ave.

VS 151

186a

G758t9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G758t9

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Katherine V. Schaffer

2. DATE OF DEATH 6/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Catonsville
D. STREET ADDRESS (If rural, give location) 101 Osborn Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white		12/23/1869	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md	

13. FATHER'S NAME Herman Faber

14. MOTHER'S MAIDEN NAME Charlotte Becker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Miss Elsie Schaffer, 101 Osborne Ave Cat.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal hypostatic pneumonia — Interval between onset and death: 2-3 days

DUE TO

(B) Congestive Heart Failure — ?

DUE TO

(C) Arteriosclerotic CVD — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/22/ 1949, to 6/30, 1949 *that I last saw the deceased alive on* 6/30 1949 *and that death occurred at* 1 10 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert J. Lerches M. D.	St. Agnes Hospital	6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 4/49	Loudon Pk.	3801 Frederick Rd. Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	Harry H. Nuttle & Son	4101 Edmondson Ave. 937

VS 150

Please write the cause of death clearly and correct age is especially important. Physician:

G75870

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75870

Registered No.

1. NAME OF DECEASED (Type or Print) JOSEPH MARTIN VINCENT CURRAN

2. DATE OF DEATH June 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3026 Garrison Blvd.

c. Length of stay in Baltimore Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-38
D. STREET ADDRESS (If rural, give location) 3026 Garrison Blvd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Male	white	Widower	Jan. 5, 1875	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Real Estate Agent	owner	Baltimore, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Curran	Mary Hoban

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (ADDRESS)
no		none	3026 Garrison Blvd. Mrs. Barbara C. Miller

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
(A)	Cerebral Hemorrage	6/26/49
DUE TO (B)	Chr. Myocarditis	1945
DUE TO (C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Apr. 28, 1949 *to* June 30, 1949 *that I last saw the deceased alive on* June 29, 1949 *and that death occurred at* 7.45 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Parker Brown M. D.	1663 W. North Ave	6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 2, 1949	New Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Eustace Williams, M.D.	Chas. J. Evans & Son, Inc.	118 West Mount Royal ave. Balto.

VS 150

931

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G75871 ✓ ✗ 443 G75871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Gertrude B. Garver — Gertrude Mariner

2. DATE OF DEATH June 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md. B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pasadena
D. STREET ADDRESS (If rural, give location) R.D. #1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	4-11-99	50	2	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Va.	U.S.A.

13. FATHER'S NAME Charles Murphy

14. MOTHER'S MAIDEN NAME Hattie Crockett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident-left — INTERVAL BETWEEN ONSET AND DEATH: 2½ d.

DUE TO

(B) Hypertensive-Arteriosclerotic C-V. Dis.

DUE TO

(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Obesity - exogenous

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-27, 1949 *to* 6-29, 1949 *that I last saw the deceased alive on* 6-29, 1949, *and that death occurred at* 6:30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. D. Buchanan M. D.	JOHNS HOPKINS HOSPITAL	6/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 2, 1949	Glen Haven Cemetery	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	George J. Smith Inc.	1735 Harford Ave.

VS 150

93D

Be sure age is especially important. Physician: please write plainly and fill out cause of death clearly and legibly.

G75872

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

57 0 5

G75872 Registered No.

1. NAME OF DECEASED (Type or Print): Catherine Schultheis

2. DATE OF DEATH: 30 June 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: 12 Days. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Mt. Wilson Sanatorium
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mt. Wilson, Md.
D. STREET ADDRESS (If rural, give location): 2040 Kennedy Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	25 Dec 1878	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Schultheis

14. MOTHER'S MAIDEN NAME: Ella Casilda Mancella

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Dsecased ADDRESS

MEDICAL CERTIFICATION

Please write the cause of death clearly and correct age is especially important. Physician:

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

(B) Embolii

DUE TO

(C) Unknown source & cause

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Old pulmonary TBC
Intestinal obstruction

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
19 June 1949	Dilated large bowel	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 18 June, 1949, *to* 30 June, 1949, *that I last saw the deceased alive on* 30 June, 1949, *and that death occurred at* 4:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James McC. Feeney M. D.	Univ. Mem. Hospital	30 June 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July-2-1949	Baltimore Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 1 1949	Huntington Williams, MD	Stewart & Mowen Co. - 108 W. North Avenue

VS 150

122B City #1.

G75873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75873

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Gertrude Agnes Sheehan

2. DATE OF DEATH June 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR [redacted] (If not in hospital or institution, give street address or location) St. Joseph's
c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 535 Benninghaus Rd. 27-48

5. SEX F
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Apr-28-1900
9. AGE (In years last birthday) 49-2-2 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator
10B. KIND OF BUSINESS OR INDUSTRY Md. Casualty Co.

11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Dennis Sheehan
14. MOTHER'S MAIDEN NAME Mary A. Doherty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 212-10-3736
17. INFORMANT Miss Helen DeC. Sheehan, ADDRESS Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Spontaneous pneumothorax
DUE TO
(B) Pulmonary tuberculosis, moderately advanced
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonitis - left base

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 30, , 1949 *to* June 30, , 1949 *that I last saw the deceased alive on* June 30, 1949 *and that death occurred at* 10:40 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE J. Joseph Krejci M. D.
23B. ADDRESS 1400 N. Caroline St.
23C. DATE SIGNED June 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July-2-1949
24C. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 1 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Stewart & Mowen Co., ADDRESS 108 W. North Ave.

VS 150

13B City #1.

Please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and correct age is especially important.

G75874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75874

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Jane Mary Robison

2. DATE OF DEATH: June 30/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION: (If not in hospital or institution, give street address or location) at home

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 157 W Lanvale 11-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	11-8-1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	Balto. Md.	U.S.

13. FATHER'S NAME: Cumberland Dugan

14. MOTHER'S MAIDEN NAME: Harriet Buchanan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	None	Miss	

MEDICAL CERTIFICATION

Please write the cause of death clearly and fully. Physician: please be sure that age is especially important.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis generalized — 5 years

DUE TO

(C) Paralysis agitans — 3 years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from April 15th, 1949, to June 30th, 1949, that I last saw the deceased alive on June 30th 1949, and that death occurred at 10:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leonard S. Leland M.D.	1300 N. Calvert St.	7-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 5 '49	Arlington Meth.	Arlington Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Thurlington Williams, MD	Stewart & Thomas	Balto

VS 150

87c

G75875 1-T

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75875

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Ida Hoffman HOFMAN — 2. DATE OF DEATH 6/30/49

3. PLACE OF DEATH: A. Baltimore City, Maryland St. Agnes

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hosp.

c. Length of stay in Baltimore 67 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Md. A. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2811 Hammonds Ferry Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 1 Day: Hours / Min.
female	white	widowed	10-16-1863	85 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Md. Germany	

13. FATHER'S NAME George - unknown

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.

17. INFORMANT Henry Hofman ADDRESS 1 Third Ave Lansdowne

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anterior Coronary Occlusion
DUE TO
(B) Arteriosclerotic CVD
DUE TO
(C) Pneumonia, left lower lobe

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-9, 1949, *to* 6/30, 1949 *that I last saw the deceased alive on* 6/30 1949 *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert J. Loucks M. D.	St. Agnes Hospital	6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/2/49	London Pk Cem	3501 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR JUL 1 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR Ellis Lamborn — ADDRESS 4510 Liberty Hts Ave

VS 150

108

G75876

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

44 G75876

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE A. RAFUSE

2. DATE OF DEATH: 1 July 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 27 N. CAREY ST
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): GOOD SAMARITAN HOSPITAL
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-1
D. STREET ADDRESS (If rural, give location): 38 N Hanover St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Married	July 15, 1903	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Norwood. Mass
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: George F Rafuse
14. MOTHER'S MAIDEN NAME: Susan J Archibald
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 579-16-2872
17. INFORMANT: Good Samaritan Home — ADDRESS: 298 Cary St

MEDICAL CERTIFICATION

Please write the cause of death clearly and correct age in especially important. Physician:

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of mouth + throat — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 15 June, 1949, *to* 1 July, 1949 *that I last saw the deceased alive on* 1 July, 1949, *and that death occurred at* 6^20 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: Emil A. Henning Jr M.D.
23B. ADDRESS: 4580 Edmondson Ave (29)
23C. DATE SIGNED: 1 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/1/49
24C. NAME OF CEMETERY OR CREMATORY: Highland
24D. LOCATION (City, town, or county) (State): Howard Mass

DATE RECEIVED BY LOCAL REGISTRAR: JUL 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilson & Son — ADDRESS: 1217 Park St

VS 150

45F

G75877 ✓ + G75877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Sarah Cassandra Demarest**

2. DATE **July 1st, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Aged Women's and Aged Men's Homes**
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY **Carroll**
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Rural**
D. STREET ADDRESS (If rural, give location) **Taneytown**

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	**White**	**Widowed**	**Feb. 4, 1867**	**82**	**4 / 27**	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME **Charles A. Sponsler**

14. MOTHER'S MAIDEN NAME **Clara Jane Reaver**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT **L. H. Read** ADDRESS **1400-04 W. Lexington Street**

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) **Hypostatic Pneumonia**	**1 week**
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) **Arteriosclerotic Cardio-Vascular Disease**	**3 years**
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	**Senility**	**6 mos**

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **June**, 19**48** *to* **July 1st**, 19**49** *that I last saw the deceased alive on* **July 1st**, 19**49** *and that death occurred at* **12:20** *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Newland Edmund Day M. D.	**4-E-33rd St Balto 18**	**July 6 1949**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Burial	**7/5/49**	**Woodlawn**	**Woodlawn Md**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	**Thurlington Williams, M.D.**	**Wilson & Son**	**1214 Eutaw St**

150

93D

Cross out the cause of death clearly and legibly. Physician please write this especially important.

G75878

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75878

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES EDWARD ROZIER

2. DATE OF DEATH June 29, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
708 McCabe Ave.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-10
D. STREET ADDRESS (If rural, give location) 708 McCabe Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Dec. 5, 1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Building	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nelson Rozier	Mary R. Halbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		218-14-7420	Mrs Doris Rozier	708 McCabe Ave.

MEDICAL CERTIFICATION

Please write the cause of death clearly and correct age is especially important. Physicians: please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

DUE TO

(B) Arteriosclerotic Cardio-Vascular Disease

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 2 1949 *to* 29 June 1949, *that I last saw the deceased alive on* 28 June 1949 *and that death occurred at* 10:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Kenneth H. Kammer Jr. M.D.	501 Sheridan Ave.	1 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, County or State)
Burial	7/2/49	Moreland Park	Baltimore County Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington Williams, M.D.	William Cook, Inc.,	1217 St. Paul St.

VS 150

931

CERTIFICATE CORRECTED 7-1-49

G75879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75879

BIRTH NO. G75879

1. NAME OF DECEASED (Type or Print) MARY JANE CHILDS

2. DATE OF DEATH JULY 1ST - 1949

3. PLACE OF DEATH: X Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND - B. COUNTY BALTO. CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE, MD.
D. STREET ADDRESS (If rural, give location) 9 N. WICKHAM RD. 28-4

5a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) X 9 N Wickham Rd

5c. Length of stay in Baltimore: 80 Yrs. 7 Mos. 17 Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F.	W.	WIDOWED	NOV. 13 1868	80	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE.	X	BALTIMORE, MARYLAND	U.S.A.

13. FATHER'S NAME: GEORGE W. NALLY

14. MOTHER'S MAIDEN NAME: SARAH C. NALLY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO.		X

17. INFORMANT: Mrs. Kathy C.T. Childs ADDRESS: 9 N. WICKHAM RD.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician is especially important. Please be exact.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident

DUE TO

(B) Hypertensive Cardio-Vas. Disease. & Heart enlargement, + ankle edema - etc.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
12:30 PM JUNE 30TH 1949
DIED - 4:15 P.M.
1929 -

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
X	X	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
X	X	X

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
X m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	X

22. I hereby certify that I attended the deceased from JUNE 30, 1949, to JULY 1, 1949, that I last saw the deceased alive on JUNE 30 1949, and that death occurred at 4:15 A m., from the causes and on the date stated above.

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
Thomas E. Wheeler	Liberty + Gilmor Sts. Randallstown Md.	JULY 1ST. 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/5/49	Mt Olivet	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Washington Williams Asst	Wilhorn & Son	1217 E Oval St

VS 150

93D

G75880

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 G75880

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clara J. Sheffield

2. DATE OF DEATH: June 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4402 Roland Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

c. Length of stay in Baltimore: 89 22 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4402 Roland Avenue 27-14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	July 28, 1859	89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Conn

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Jones

14. MOTHER'S MAIDEN NAME: Harriet Reck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Anna F. Muse ADDRESS: 4402 Roland Ave.

MEDICAL CERTIFICATION

(Please write the cause of death clearly and correct age is especially important. Physician: please write the

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Not known.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1939, *to* June 30th, 1949, *that I last saw the deceased alive on* June 20, 1949, *and that death occurred at* 5:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter E. Greenlee M. D.

23B. ADDRESS: Medical Arts Bldg.

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 7/2/49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 1 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Plac

John O. Mitchell

937

Vs 150 Dr. Walter E. [illegible]

G75881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 974.0 G75881

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print) JOHN Schaubhut — N-991 — 2. DATE OF DEATH June 30, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 2234 W. Saratoga St.
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2234 W. SARATOGA St.
c. Length of stay in Baltimore 40 YRS. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 20-2
D. STREET ADDRESS (If rural, give location) 2234 W. SARATOGA St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	White	Widowed	August 21, 1879	69	10	9	-	-

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
GLASSWORKER	Bottle Making	Pennsylvania	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frederick Schaubhut	Fredericka Grosshuff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	NONE		Elizabeth Meyers	2234 W. Saratoga

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Strangulation due to
DUE TO hanging
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	2234 W. Saratoga Street

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
June 30, 1949 ? m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Hanged self by bathrobe cord

22. *I certify that I took charge of the remains described above, held an* ~~Inquest~~ Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ~~☒~~, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
William J. McClafferty M.D.		7-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7-4-49	Loudon PARK	BALTIMORE Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 1 1949	Huntington for Williams M.D.	GEO. L. Schwab	2101 Frederick Ave City

VS 151

164a

Please write the exact age is especially important. Physician: please write the cause of death clearly and legibly.

G75882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E81-4

Registered No. G75882

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RAYMOND ROGER O'NEILL N-803-4

2. DATE OF DEATH July 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 20 North Calhoun Street 19-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	8/28/45	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Penna

12. CITIZEN OF WHAT COUNTRY? -

13. FATHER'S NAME Hugh K. O'Neil

14. MOTHER'S MAIDEN NAME Anna M. Vaskevich

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Hugh K. O'Neil - above ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ ~~CAUSE OF~~ DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Calhoun St., 170' South of Fayette St

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 1, 1949 ? A. m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Pedestrian struck by auto 19/2

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 7-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 4-49	New Cathedral	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 2 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR Poff & B. M. Walker ADDRESS Oliver & Fayette Sts

170 c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G75883
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 75883

1. NAME OF DECEASED (Type or Print) IDA M. STOCKSDALE

2. DATE OF DEATH June 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland B. 1302 W. Lexington St. (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1021 Light Street

c. Length of stay in Baltimore: Yrs. Life Mos. Days

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Feb. 23, 1890

9. AGE (In years last birthday): 59 — If Under 1 Year: Months 4, Days 7 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Sanders

14. MOTHER'S MAIDEN NAME: Lydia Ann Benton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Mary C. Johnson ADDRESS: 1017 Light Street

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Cerebro-vascular disease — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* June 12th, 1949 *to* June 29, 1949 *that I last saw the deceased alive on* June 29, 1949 *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Harry Glassman M. D.

23B. ADDRESS 753 W. Fayette St

23C. DATE SIGNED June 30 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/4/49

24C. NAME OF CEMETERY OR CREMATORY London Park

24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 2 - 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR: William Cook, Inc. ADDRESS: 1217 St. Paul Street

Vs 150

937

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G75884

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75884

1. NAME OF DECEASED (Type or Print) Harry R. McAllister

2. DATE OF DEATH June 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ardleigh Nursing Home 2075 Rockrose Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2451 Barclay Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Divorced	Nov. 15, 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Watchman	Dietrich Steel Co.	Baltimore, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James McAllister	Sarah F. Picket

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	---	215-24-9231	Mr. John McAllister	2545 Kirk Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B) Arteriosclerosis
DUE TO
(C) Infiltration of p. lung

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 1947 *to* June 1949 *that I last saw the deceased alive on* June 28 1949 *and that death occurred at* 5 p *m. from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
K. Trangott M. D.	1623 E. N. Avenue	July 1 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Burial	7/2/49	Loudon Park Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 2- 1949	Washington Williamson, M.D.	Wm. Cook, Inc.,	1217 St. Paul Street

VS 150

94a

Please write the cause of death clearly and correct age is especially important. Physician:

G75885

JL 130002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G75885

1. NAME OF DECEASED (Type or Print) Susan Hartman

2. DATE OF DEATH 6-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 502 S. Hendrix Ave.

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH Feb. 8, 1861

9. AGE (In years last birthday) 88 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Antone LEONHARDT

14. MOTHER'S MAIDEN NAME Madeline WHITMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT B. C. H. Records, ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

Write the cause of death clearly and forcibly. Physician: please write the cause of death clearly and forcibly. Be specific; please

G75886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75886

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Louis Appel

2. DATE OF DEATH July 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 813 N. Lakewood Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 813 N. Lakewood Ave.,

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	May 13, 1906	43				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	

13. FATHER'S NAME: Edward A.A. Appel

14. MOTHER'S MAIDEN NAME: Junette B. Miskimon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	217-03-2965	Edward A.A. Appel	813 N. Lakewood Ave.,

MEDICAL CERTIFICATION — please write the cause of death clearly and correct age is especially important. Physician:

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH 6/6 to 7/1/49

DUE TO ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Polio. in infancy

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/6, 1949, to 7/1, 1949, *that I last saw the deceased alive on* 7/1, 1949, *and that death occurred at* 5:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis F. Klimes KLIMES, M. D.	2623 E. Monument St	7/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 5, 1949	Parkwood	Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 2 - 1949	[illegible]	Ullrich Funeral Home	2008 Orleans St.,

VS 150

94a

G75887

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13 G75887

Registered No.

1. NAME OF DECEASED (Type or Print) Mrs. Katherine Hose HEESE

2. DATE OF DEATH 30 June 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. Length of stay in Baltimore 69 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 13.

D. STREET ADDRESS (If rural, give location) 2405 E. Hoffman St. 8-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	31 Aug 1880	65 69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore Md	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Baumgartner	Katherine Dimmling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			William Heese (Husband)	same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Arteriosclerosis, generalized

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypostatic pneumonia cardiovascular disease

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 27 June, 1949, *to* 30 June, 1949, *that I last saw the deceased alive on* 30 June, 1949, *and that death occurred at* 8:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. A. Cox M.D.	Union Memorial Hospital	6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 5, 1949	Baltimore	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 2 - 1949	Huntington Williams, M.D.	Ulrich Funeral Home	2901 Wilkens Ave

VS 150

93D

Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

G75888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33

Registered No. G75888

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles D. Salsberg

2. DATE OF DEATH July 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3423 E Pratt St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3423 E. Pratt St 26-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	May 5, 1866	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Sweden	

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		—	Chas. D. Salsberg	343 E. Pratt St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) CEREBRAL THROMBOSIS	10 D/S
	DUE TO (B) ARTERIOSCLEROSIS, GENERALIZED	10 YRS.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 14 JUNE 19 49 *to* 1 JULY, 19 49 *that I last saw the deceased alive on* 30 JUNE 19 49 *and that death occurred at* 8 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Lichtstein M. D.	121 S. HIGHLAND AVE	9 JULY, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Burial	July 5, 1949	Oak Lawn	Colgate Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 2 - 1949	Huntington Williams, M.D.	Ulmer Funeral Home	Wilson St

VS 150

836

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75889

Birth No. 5889

1. NAME OF DECEASED (Type or Print): JESSE ESSLINGER, Sr.

2. DATE OF DEATH: June 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
FULL NAME OF HOSPITAL OR INSTITUTION* (If not in hospital or institution, give street address or location): 3915 Walnut Ave.
c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 3915 Walnut Ave. 27-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
male	white	married	July 11th, 1872	76	11	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Paper Carrier	Daily Papers (Sun)	Baltimore, Md.	

13. FATHER'S NAME: Jesse Esslinger

14. MOTHER'S MAIDEN NAME: Elizabeth Dye

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Mrs. Jesse Esslinger, Sr. ADDRESS: 3915 Walnut Ave.

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write the cause of death clearly and fully.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerosis (Cardiac) — INTERVAL BETWEEN ONSET AND DEATH: 7 years
DUE TO
ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) /
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Malnutrition,

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 2, 1949, *to* June 30, 1949 *that I last saw the deceased alive on* June 30, 1949 *and that death occurred at* 8 4 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles V. Sevens M. D.	1 W Averlea Ave.	7/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/4/49	Parkwood	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 2- 1949	Huntington Williams, M.D.	Lassahn Funeral Home	7401 Belair Rd.

VS 150

97

G75890 X ✓ Eg 12.5 G75890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KENNETH CHANDLER Miles — N-874.2 — 1

2. DATE OF DEATH: June 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~Maryland~~ MASS.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cambridge
D. STREET ADDRESS (If rural, give location): 336 Concord Ave

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 3/29/26
9. AGE (In years last birthday): 23 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Messman
10B. KIND OF BUSINESS OR INDUSTRY: Maritime Serv.
11. BIRTHPLACE (State or foreign country): Boston, Mass
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John DAVIS Chandler
14. MOTHER'S MAIDEN NAME: Elleanor Graves

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: John E. Chandler — ADDRESS: 334 Concord

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Stab-wound of neck.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Pennsylvania Avenue & Pitcher St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 30, 1949 2 A. m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Sharp Instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

23A. SIGNATURE: George C. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: June 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 7/5/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Cambridge, Mass.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 2 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Charles R. Law
ADDRESS: 802 Mad. Ave

VS 151

correct age is especially important. Physician: please write the cause of death clearly and fully.

167 ✓1

G75891
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

31 G75891
Registered No.

1. NAME OF DECEASED (Type or Print): Mamie Ryan.

2. DATE OF DEATH: 6-29-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1105 Mc Kean Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1105 Mc Kean Ave.,
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-04
D. STREET ADDRESS (If rural, give location): 1105 Mc Kean Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	C	Single	Jan. 1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Howard County, Md	U.S.A.

13. FATHER'S NAME: Thomas Ryan
14. MOTHER'S MAIDEN NAME: Emily Boardley.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Olivia Ryan.	1105 Mc Kean Ave

MEDICAL CERTIFICATION

Please write the cause of death clearly and forcibly. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 da.
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 6-27-1949 to 6-29-1949, that I last saw the deceased alive on 6-28-1949 and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm R Boyle M.D.	1133 N. Monroe	7-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-2-49	Western Star Cem.	Catonsville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 2- 1949	Huntington Williams, MD	Mrs Kate R Williams	3221 W Lafayette

VS 150

83a

G75892

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75892

1. NAME OF DECEASED (Type or Print) Thomas Kendricks

2. DATE OF DEATH JUN 30 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 721 Waesche st

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
d. STREET ADDRESS (If rural, give location) 721 Waesche St 4-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	Cld	Married	Dec 2 1908	40				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver		Sumter - S. C	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Kendricks	Liza Bennett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		Mary Hendricks	721 Waesche St

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 7

DUE TO

(B) Myocardial Infarction — 2 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 1949 to June 30 1949, that I last saw the deceased alive on June 30 1949, and that death occurred at 12 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles T. Wadell M.D.	861 Hanover St	7/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-2-49	Sumter S.C.	S.C.

DATE RECEIVED BY LOCAL REGISTRAR JUL 2 1949 — REGISTRAR'S SIGNATURE for Thomas, M.D.

25. FUNERAL DIRECTOR Mrs Katie R. Williams — ADDRESS 3221 Schroeder

VS 150

92D

G75893
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75893
Registered No.

1. NAME OF DECEASED (Type or Print): KATHARINE APPLE SLAGLE

2. DATE OF DEATH: June 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2610 Shirley Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2610 Shirley Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
female	white	married	Jan. 23, 1858	91 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	Home	Pennsylvania	

13. FATHER'S NAME: Dr. Thomas G. Apple

14. MOTHER'S MAIDEN NAME: Emma Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		no	Miss Emma A. Slagle	2610 Shirley Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocarditis
DUE TO Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Gradual

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 1943 *to* June 30, 1949 *that I last saw the deceased alive on* June 29, 1949 *and that death occurred at* 11 45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. R. Moody M.D.	1403 Park Ave Balto Md	July 5 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/2/49	Mt. Olivet Cem.	Hanover, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

937

Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

G75894

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75894

1. NAME OF DECEASED (Type or Print): BARBARA L. MORSE

2. DATE OF DEATH: June 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2904 Overland Ave.

c. Length of stay in Baltimore: Yrs. Life -- Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2904 Overland Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year, Months	Days	If Under 24 Hours, Hours	Min.
female	white	single	Nov. 4, 1859	89 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired School Teacher	Public Schools	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Stephen A. Morse	Sarah McGlone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-		-	Mrs. Bessie Gordon	2904 Overland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic C.V.D

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. , 1949 to June 30 , 1949, *that I last saw the deceased alive on* June 29 , 1949, *and that death occurred at* 1:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Harry Shaw M. D.	4218 Harford Rd.	7/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/2/49	Loudon Park Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 2 - 1949	Thurlington Williamson, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

93D

Write the cause of death clearly and correct age is especially important. Physicians: please write this

G75895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

Registered No. G75895

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Martha B. Haynie

2. DATE OF DEATH July 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2230 Madison Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 45 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2230 Madison Ave. 13-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Negro	Widowed	5/26/79	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Northumberland Co., Va.	

13. FATHER'S NAME George Bell

14. MOTHER'S MAIDEN NAME Hester Waters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Mildred Bradley ADDRESS

MEDICAL CERTIFICATION

Correct age in especially important. Physician: please write the cause of death clearly and fully.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aortic Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO Myocardial Insufficiency

(B) Hypertension — ?

DUE TO Arteriosclerosis

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-1- 1949 *to* 7-2 1949, *that I last saw the deceased alive on* 7-2- 1949, *and that death occurred at* 7:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Lucy E. Haynie M. D.

23B. ADDRESS 2224 Madison Ave

23C. DATE SIGNED 7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/6/49

24C. NAME OF CEMETERY OR CREMATORY St. Peters

24D. LOCATION (City, town, or county) (State) Northumberland Co., Va.

DATE RECEIVED BY LOCAL REGISTRAR JUL 2 1949

REGISTRAR'S SIGNATURE Emily Jon Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Charles R. Law - 802 Mad. Ave.

VS 150

92a

G75896

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

151

G75896

Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Nowak

2. DATE OF DEATH: June 30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1125 S. Lakewood Ave

C. Length of stay in Baltimore: 50 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 1-04
D. STREET ADDRESS (If rural, give location): 1125 S. Lakewood Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	March 19 1858	91		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Labor. B.O.Rr.

11. BIRTHPLACE (State or foreign country): Poland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Nowak

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Walter Nowak ADDRESS: 1125 S Lakewood

MEDICAL CERTIFICATION

Complete the cause of death clearly and legibly. Physician please write in ink. Correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: May 1 1949

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	None	None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
None m.	WHILE AT WORK ☐ None WHILE AT WORK ☐	None

22. *I hereby certify that I attended the deceased from* May 1 1948 *to* June 30, 1949 *that I last saw the deceased alive on* June 29 1949, *and that death occurred at* 11:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Gathemunk M. D.	842 S Eaton	7-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 4-1949	Holy Cross	Garmanhill Rd. Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 2 - 1949	Huntington Williamson, M.D.	Doppel Bros.	1800 E. Lombard St.

VS 150

46B

G75897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75897

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Frank Cincotta**

2. DATE OF DEATH **June 30 1949**

3. PLACE OF DEATH: **Baltimore City, Maryland** **2123 E. Pratt St.**

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

3c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **2123 E. Pratt St.**

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
male	white	Married	June 19 1885	64	11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fruit & Produce	Soph Employed	Italy	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Cincotta	Angelina Lonegro

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Angela M. Regula	2123 E. Pratt St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of Liver — INTERVAL BETWEEN ONSET AND DEATH: 1 yr +

DUE TO

(B) Arteriosclerosis — 1 yr +

DUE TO Actual Hypertension

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1949 *to* June 30, 1949 *that I last saw the deceased alive on* June 30, 1949, *and that death occurred at* 8:05 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. D. Lyford, M. D.	727 S. Patterson Park Ave	7/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 4th 1949	Holy Redeemer Cemetery	4430 Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 9 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Procula Della Vecc — ADDRESS: 322 S. High St.

VS 150

124B

Write the cause of death clearly and correct age is especially important. Physician: please write legibly.

BIRTH NO. G75898

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E816.7 G75898 Registered No.

1. NAME OF DECEASED (Type or Print): LILLIAN LEWIS N

2. DATE OF DEATH: July 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Belair
D. STREET ADDRESS (If rural, give location): 126 N. Maine Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White			53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

(Physician: please write the cause of death clearly and correct age is especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushed chest
DUE TO
(B) Fractured leg and wrists
Multiple lacerations, contusions, and abrasions.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] ~~CAUSE OF~~ DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	street	Route #1, Kingsville, Maryland Balto. Co.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21F. HOW DID INJURY OCCUR?
July 2, 1949 1 A m.		Auto into rear of parked auto

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
George H. Merrill M.D.		7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 5 1949	Joshua Thomas	Darlington Md Harford Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949		H. B. Bailey	Darlington Md

VS 191

170c

G75899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75899
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harry Bloom.

2. DATE OF DEATH July 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore City Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Beaver
D. STREET ADDRESS (If rural, give location) 958 Fourth Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	10-6-1930	18	9			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	School	Beaver Pa	

13. FATHER'S NAME Hulmer V Bloom

14. MOTHER'S MAIDEN NAME Marion Mc Candless

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N		none	Hulmer V Bloom	Beaver Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Anoxia
DUE TO
(B) Laryngospasm
DUE TO
(C) Pulmonary TB. - Rt. Apex

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/2/49	Post-operative scar in posterior pharynx	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/1, 1949 *to* 7/2, 1949 *that I last saw the deceased alive on* 7/2, 1949 *and that death occurred at* 5:35 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter J. Bernard M. D.	St. Agnes Hospital	7/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/3/49	Beaver	Beaver Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 3 1949	Huntington Williams, M.D.	Wilson & Son	1217 St Paul St
JUL 3 1949			

13 B

Write the cause of death clearly and legibly. Physician: please write the... important. Especially is especially...

G75900 ✓Vest X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 16 G75900

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frankie Vest

2. DATE OF DEATH July 2 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE W. Va. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Charleston -

D. STREET ADDRESS (If rural, give location) 520 Ford St -

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 1 Day Hours	Min.
Male	White		10-21-36	12				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	—	W. Va. -	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Vest.	Ruth Richmond.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
				JOHNS HOPKINS HOSPITAL ✓

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician please write correct age is especially important.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Heart Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 13 20 1949 to July 2 1949 *that I last saw the deceased alive on* July 2, 1949, *and that death occurred at* 8 20 P m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William McKenzie M. D.	JOHNS HOPKINS HOSPITAL	7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	State
Removal	7/3/49	Greenmount Funeral Home	Charleston W. Va	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 3 1949	Huntington Williams M.D.	Earl B. Wharton	403 E. 25 St.

58 D

G75901 G75901 01

BALTIMORE CITY HEALTH DEPARTMENT 43
CERTIFICATE OF DEATH Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LOUISE ANNE WIESENER

2. DATE OF DEATH JULY 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
346 E BELVEDERE AVE.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN BALTO. (If outside corporate limits, write RURAL and give township) 27-12
D. STREET ADDRESS (If rural, give location) 346 E. BELVEDERE AVE.

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED
8. DATE OF BIRTH 12-25-1861
9. AGE (In years last birthday) 88 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) TENN.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME JAMES THIRLKELD
14. MOTHER'S MAIDEN NAME SUSAN ELWEANNA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, more unknown) NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS ERICH WIESENER, RIDGEWOOD N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(B) Arterio-Sclerosis Myocarditis Hypertension — Estimated
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 1948 *to* July 2, 1949, *that I last saw the deceased alive on* July 2, 1949, *and that death occurred at* 3 P. m. *from the causes and on the date stated above.*

23A. SIGNATURE W. H. Moody M. D.
23B. ADDRESS 1403 Park ave
23C. DATE SIGNED July 3, 49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 7-5-1949
24C. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK
24D. LOCATION (City, town, or county) PARAMUS (State) N.J.

DATE RECEIVED BY LOCAL REGISTRAR JUL 3 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR H. W. JENKINS & SONS CO.
ADDRESS 4908 YORK RD BALTO. 12

VS 150

93D

G75902

BIRTH NO. G75902

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 02

1. NAME OF DECEASED (Type or Print): Isaac Gross

2. DATE OF DEATH: June 30th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 27 N. Carey St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Hospital 27 N. Carey St
C. Length of stay in Baltimore: 60 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1527 Myrtle Avenue
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): Same 14-07

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Feb. 6 1872
9. AGE (In years last birthday): 77 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Easton Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Henry Gross
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: None
17. INFORMANT
ADDRESS

MEDICAL CERTIFICATION — Please write the cause of death clearly and legibly. Physician's please write in ink. Correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocarditis + Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) Arteriosclerosis — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 11, 1949 to June 30, 1949 that I last saw the deceased alive on June 30, 1949 and that death occurred at 4.50 P m., from the causes and on the date stated above.

23A. SIGNATURE: Melvin N. Borden M. D.
23B. ADDRESS: 2030 W. Fayette St
23C. DATE SIGNED: 6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 4 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JUL 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph L. Russ
ADDRESS: 1206 N. Caroll

VS 150

937

G75903 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

177 Registered No. G7590303

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BLOSS, JOSEPH RANDOLPH

2. DATE OF DEATH July 1 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL

c. Length of stay in Baltimore Yrs. 6 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE ROGERSAVE - ELLICOT CITY MD. Howard
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) (Rural) Ellicott City
D. STREET ADDRESS (If rural, give location) Rogers Avenue

5. SEX male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH June 17 1880
9. AGE (In years last birthday) 69
If Under 1 Year: Months — Days 14
If Under 24 Hours: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Collector (Retired)
10B. KIND OF BUSINESS OR INDUSTRY Collections Agency
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Bloss
14. MOTHER'S MAIDEN NAME Emma Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-01-3262
17. INFORMANT Mrs. Inez V. Hewett, Ellicott City, Md. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malignancy of prostate — INTERVAL BETWEEN ONSET AND DEATH 5-6yrs
DUE TO
(B) —
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION June 5 1949
19B. MAJOR FINDINGS OF OPERATION Malignancy of the prostate with metastasis
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/11 1949 *to* 7/1 1949 *that I last saw the deceased alive on* 7/1 1949 *, and that death occurred at* 1:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE M. D. Rodberger
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 7/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 4, 1949
24C. NAME OF CEMETERY OR CREMATORY Lord Shepherd Cemetery
24D. LOCATION (City, town, or county) (State) Ellicott City, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR JUL 3 1949
REGISTRAR Johns Hopkins Hospital, Md.
25. FUNERAL DIRECTOR Easton Sons
ADDRESS Ellicott City, Md.

VS 150

51B

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

BIRTH NO. G75904

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75904

Registered No.

1. NAME OF DECEASED (Type or Print): WADE HAMPTON HAMMOND

2. DATE OF DEATH: July 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

C. Length of stay in Baltimore: 15 yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore (Essex)
D. STREET ADDRESS (If rural, give location): 7531 Eastern Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White		Jan 6 - 1904	45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Policeman

10B. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Oglethorpe Co, Georgia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wade R Hammond

14. MOTHER'S MAIDEN NAME: mary Eliz. Burt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs I.W.H. Anderson ADDRESS: Athens Georgia

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary thrombosis
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION -

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George H. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/3/49	Oconee Cem.	Athens Georgia

DATE RECEIVED BY LOCAL REGISTRAR: JUL 3 1949

REGISTRAR'S SIGNATURE: Lon Williams M.D.

25. FUNERAL DIRECTOR: John D Connelly. ADDRESS: Eden 24 md.

94a

Please write the cause of death clearly and legibly. Physician: please write exact age if especially important.

G75905 BALTIMORE CITY HEALTH DEPARTMENT G75905

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) MRS. MARY ANDREWS

2. DATE OF DEATH 7-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) PINE RIDGE CONVALSCENT HOME

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 529 EAST 41 ST. 9-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	WIDOWED	OCT. 2-1865	83 84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	NEW YORK STATE	—

13. FATHER'S NAME AARON WHITEHEAD

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT AARON ANDREWS ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-vascular-renal disease

DUE TO

(B) Parkinsonism

DUE TO

(C) Cardiac failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 1949 *to* 7-3 , 1949 *that I last saw the deceased alive on* 7-2 1949, *and that death occurred at* 7 45 *A.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. L. Ewart Jr. M. D.	36 York Ct.	7/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	7-5-49	Poultney Cem.	Rawlinsburg - N. Y.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 4 1949	Carrington Williams, MD	Thos. J. Kenny Inc. 1600 Hollins St.

VS 15b

1312

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

BIRTH NO. G75906

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75906

1. NAME OF DECEASED (Type or Print) Ester Rodey

2. DATE OF DEATH July 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Calvert
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Leonard
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Child	6-29-49			3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Donald Rodey

14. MOTHER'S MAIDEN NAME Ester Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Heart failure	3 days
	DUE TO (B) Congenital heart disease	3 days
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 6-30, 1949 *to* 7-2, 1949, *that I last saw the deceased alive on* 7-2, 1949, *and that death occurred at* 10 30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. H. Zuckerman, M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 4, 1949	St. Paul's M.E	Lusby Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Lurlington Williams, M.D.	A. A. Hasknell & Son	Mutual Md.

157E

Please write the cause of death clearly and legibly. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75907 (6 r G75907)

BIRTH NO. G75907

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Timothy Knepper.

2. DATE OF DEATH: July 3 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital.

c. Length of stay in Baltimore: 10 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Allegany
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cumberland
D. STREET ADDRESS (If rural, give location): Route 5.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Infant.	June 16 1949			16.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wilmer
14. MOTHER'S MAIDEN NAME: Agnes Resting

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: J. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulm. Atelect., Congestion & Edema.
DUE TO
(B) Acute gastric dilitation.
DUE TO
(C) Dermoid cyst - tongue.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 7-2-49
19B. MAJOR FINDINGS OF OPERATION: Removed Dermoid Cyst - tongue.
20. AUTOPSY? YES [x] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-25, 1949 *to* 7-3, 1949 *that I last saw the deceased alive on* 7-3, 1949 *and that death occurred at* 6:30 A. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Cuthbert T. Hall Jr. M. D.
23B. ADDRESS: St. Agnes Hosp.
23C. DATE SIGNED: 7-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 5, 1949
24C. NAME OF CEMETERY OR CREMATORY: St Michael Cem
24D. LOCATION (City, town, or county) (State): Frostburg, Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 4 VS 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: W. H. Knight ADDRESS: Cumberland, Md.

56E

Please write the cause of death clearly and correct age is especially important. Physician:

G75908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75908

BIRTH NO.

1. NAME OF DECEASED (Type or Print) IRVIN SIEGAEL

2. DATE OF DEATH 7-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3903 Fordleigh Rd

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3903 Fordleigh Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	May 24, 1908	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Meyer

14. MOTHER'S MAIDEN NAME Ida

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Bertha Siegael ADDRESS 3903 Fordleigh

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH 8 yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* Jan. '49 19__, *to* June 30 19 49 *that I last saw the deceased alive on* June 27, 1949 *and that death occurred at* 3:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Dr. M. S. Sterling M. D.

23B. ADDRESS 2426 Eutaw Place

23C. DATE SIGNED 7/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify) CREMATION

24B. DATE 7-5-49

24C. NAME OF CEMETERY OR CREMATORY Loudon Park

24D. LOCATION (City, town, or county) Balto. (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 4 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Lewis Inc. ADDRESS 2100 Eutaw Pl

VS-150

94a

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

BC. 49-13729
G75909

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1949

BIRTH NO. G75909 Registered No.

1. NAME OF DECEASED (Type or Print) Baby Girl ~~Robert James~~ SHUGARMAN

2. DATE OF DEATH JULY 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL

c. Length of stay in Baltimore ~~Yrs.~~ ~~Mos.~~ 1 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 15-05
D. STREET ADDRESS (If rural, give location) 2711 LIBERTY HEIGHTS #15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	INFANT	JULY 2, 1949			17 30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INFANT	INFANT	MARYLAND	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
LOUIS S. SHUGARMAN	JEANNE LEDERMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO				

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) PULMONARY ATELECTASIS	17½ HRS
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐
—	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
—		—

22. *I hereby certify that I attended the deceased from* JULY 2, 1949, *to* JULY 3, 1949, *that I last saw the deceased alive on* JULY 3, 1949, *and that death occurred at* 7:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edmund B. Middleton, M. D.	UNIVERSITY HOSPITAL	JULY 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-4-49	Shaarei Tfiloh	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 4 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS-1150

161a

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G75910

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C.48-22136 CERTIFICATE OF DEATH Registered No. G75910

1. NAME OF DECEASED (Type or Print) David M. Pilkerton

2. DATE OF DEATH 7-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. Length of stay in Baltimore all life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City

D. STREET ADDRESS (If rural, give location) 3001 Independent St. 9 04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 hours: Hours	Min.
F	W	single	10-9-48		9	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Balto, Md.	U.S.

13. FATHER'S NAME Francis Pilkerton

14. MOTHER'S MAIDEN NAME Doris Arthur

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		—

17. INFORMANT mother ADDRESS ✓

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diarrhoea, dehydration — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY Ooccur?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 6-29, 1949, *to* 7-2, 1949 *that I last saw the deceased alive on* 7-2, 1949, *and that death occurred at* 6:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. Ravald Esty M. D.	Union Memorial Hosp.	6/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-5-1949	Moreland Pk. Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 4 1949	Huntington Williams, M.D.	Edward W. Conklin	924 E. Lafayette St.

VS 150

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

119a

G75911 BALTIMORE CITY HEALTH DEPARTMENT G75911
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): Michael Andre St. Croix
2. DATE OF DEATH: July 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR [redacted] (If not in hospital or institution, give street address or location): St. Joseph's
c. Length of stay in Baltimore: 6 yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 903 Rosedale Ave. 16 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M.	W.	Single	Apr. 3. 1941	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student		New York	

13. FATHER'S NAME: Michael Dow St. Croix
14. MOTHER'S MAIDEN NAME: Mary Virginia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N		none	Michael St Croix	903 Rosedale Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic glomerulonephritis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July ~~21~~ 1, 1949, *to* July 3, 1949 *that I last saw the deceased alive on* July 3, 1949 *and that death occurred at* 7:45 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thaddeus Siwinski M. D.	1400 N. Caroline St.	July 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/6/49	Holy Redeemer	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 4 1949	[redacted] Baltimore, Md.	Wm Cook Inc	127 St. Paul St.

VS 150 NOTE: Pt. admitted June 21, 1949, but not attended by me until July1, 1949. Attended by another doctor from June 21 until June 30 inclusive. 1318

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75912

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Anna Dyer

2. DATE OF DEATH: July 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 311 East 33rd Street.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	October 19, 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE		Germany	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Rehrman	Anna Herz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Frank P. Dyer	5101 Belvedere Ave Baltimore, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Probable Cerebral hemorrhage	
	DUE TO (B) Chronic lymphatic leukemia	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 1949, *to* July 2, 1949, *that I last saw the deceased alive on* July 2, 1949, *and that death occurred at* 4:25 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John Allen Smith Jr. M. D.	Mercy Hospital	7/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/3/49	New Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 4 1949	Huntington Williams, M.D.	Wilson & Son	129 Park St

74a

write the cause of death clearly and legibly. Physician: please write ... important: please ... correct age is especially

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 976.0 G75913

BIRTH NO. G75913 — Registered No. _____

1. NAME OF DECEASED (Type or Print): MARTHA J. Hess — N-853-7

2. DATE OF DEATH: July 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL, Calvert & 33rd Streets

C. Length of stay in Baltimore: Yrs. _____ Mos. _____ Days _____

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): TOWSON
D. STREET ADDRESS (If rural, give location): 111 GREENBRIER ROAD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	MARRIED	May 26, 1906	43	1	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Clarksburg, W. VA.	

13. FATHER'S NAME: Peter Swope Wheeler

14. MOTHER'S MAIDEN NAME: Drucella Grape

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Arthur Hess	111 Greenbrier Road

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bullet wound of brain	
	DUE TO	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	111 Greenbrier Rd.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 2, 1949 5:55 P.M.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	Firearms

22. *I certify that I took charge of the remains described above, held an* Aut. Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil L Beyer M.D.		3 Jul 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	July 5, 1949	GREENMOUNT	BALTIMORE, MARYLAND

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 4 1949	[illegible] Baltimore, Md.	WILLIAM COOK, INC.	1217 ST. PAUL ST.

VS 151

164 c ✓

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G75914

BIRTH NO. G75914

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

Registered No.

1. NAME OF DECEASED (Type or Print): JORGE ~~LAFORE~~ de la TORRE

2. DATE OF DEATH: 7-2-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore: Yrs. 31 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 12-2
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOGOTA COLUMBIA
D. STREET ADDRESS (If rural, give location): 7TH ST. 780.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
MALE	SPANISH	MARRIED	1-31-1905	44	6	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INDUSTRY	GLASS MANUFACTURY	BOGOTA	COLUMBIA

13. FATHER'S NAME: SIMON ~~LAFORE~~ de la TORRE

14. MOTHER'S MAIDEN NAME: MARINA COATES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		MRS. A. C. JONES	2200 LAFAYETTE AVE. BALT. MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis, peritoneal, generalized — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) ADENO-CARCINOMA, origin undetermined

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-9-1949	ENTIRE UPPER ABDOMEN INVOLVED 4 LITERS FLUID IN ABDOMINAL CAVITY WITH ADENO CARCINOMA	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-2, 1949, to 7-2, 1949, *that I last saw the deceased alive on* 7-2, 1949, *and that death occurred at* 9 40 *Am., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Green M. D.	Union Memorial Hospital	2 July '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 5th 1949	Mt. Olivet	D. C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 4 1949	Huntington Williams, M.D.	Wm Cook Inc.	217 St. Paul St.

HS 150

55C

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G75915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 3 31

G75915 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BARBARA DeBARRY

2. DATE OF DEATH: July 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 750 W. Lexington St. 4-0 v

5. SEX: Feamale
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Oct 9, 1878
9. AGE (in years last birthday): 70 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Smith
14. MOTHER'S MAIDEN NAME: Charlotte McCleary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT — ADDRESS: Mrs Dora E. Davis, 1502 Braddish Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerbrovasc. Acc.
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-1- 19[illegible] *to* 7-2- 1949 *that I last saw the deceased alive on* 7-2- 1949 *and that death occurred at* 5 3/4 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm. Hermann M. D.
23B. ADDRESS: Univ. Hosp.
23C. DATE SIGNED: 7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/5/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 150

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G75916 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G75916

BIRTH NO.

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print): Judge Anna (Anna Judge) — 2. DATE OF DEATH: July 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Hospital 27 N. Carey Street
c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 27 N. Carey St. 18-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed		70 app.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	New Jersey	USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
—		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia Rt Lobar — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Carcinoma left breast — few years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 10 1949 *to* July 3 1949, *that I last saw the deceased alive on* July 2, 1949 *and that death occurred at* 2150 *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
H. R. Johnson	403 Med Arts Bldg	7-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	July 4, 1949	Honold Funeral Home	Swedesboro, N.J.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JUL 5 1949	Huntington Williams, M.D.	John Burns' Sons, Towson, Md.

50

Please write the cause of death clearly and legibly. Physician: please write the exact age if especially important.

G75917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75917

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES SIFORD

2. DATE OF DEATH: 7/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Red Lion Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W		Oct 1872	77 76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Railroad employee	England	USA

13. FATHER'S NAME: Sidney Sford

14. MOTHER'S MAIDEN NAME: Martha Eals

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No		Mrs. M.W.Pullen, Towson, Maryland

MEDICAL CERTIFICATION

Please write to the cause of death clearly and legibly. Physician: please write exact age is especially important.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Thrombosis	5 days.
DUE TO (B)	Arteriosclerotic Cardiovascular Disease	
DUE TO (C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/29 *19*49, *to* 7/2, *19*49, *that I last saw the deceased alive on* 7/2, *19*49, *and that death occurred at* 3:25 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles J. Black Jr. M.D.	Maryland General	7/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 5, 1949	Prospect Hill Cemetery	Towson, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JUL 4 1949	Timothy Lee Williams, M.D.	John Burns' Sons, Towson, Maryland

VS 150

937

G75918 ✓ G75918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Thomas P. Joyce

2. DATE OF DEATH July 2nd 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West. Balto. Gen. Hosp. D.O.A.

C. Length of stay in Baltimore Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 3705 Gibbons Ave 27-34

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W		March 17 1905	44				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sergeant	Balto Police Dept	Frankfort Ind	U.S.A.

13. FATHER'S NAME Patrick Joyce

14. MOTHER'S MAIDEN NAME Anna McLoone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Ellen M. Joyce	3705 Gibbons Ave

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH —

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
William J. Helfrich M.D.		July 2nd 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 6 1949	Holy Redeemer Cem	Belair Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 4 1949	Tunstall for Williams, M.D.	John C. Moran	3000 E. Fayette St

VS 151

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75919 BALTIMORE CITY HEALTH DEPARTMENT G75919
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Hedwig Kuźniarski (KUZNIARSKI)
2. DATE OF DEATH 7-1-49
3. PLACE OF DEATH: A. Baltimore City, Maryland 11 S. Culver st.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 11 S. Culver St.
C. Length of stay in Baltimore Life Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 11 S. Culver St. 10-07
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct. 14-1914
9. AGE (In years last birthday) 34 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Boleslaw Miksinski
14. MOTHER'S MAIDEN NAME Stanislawa Slowacka
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Marion J. Kuzniarski ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio Vascular Disease — 1 year
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐
21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Robert B. McFadden M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED 7-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 5-1949
24C. NAME OF CEMETERY OR CREMATORY Holy Rosary
24D. LOCATION (City, town, or county) (State) Balto. Co.
25. FUNERAL DIRECTOR ADDRESS Wm. L. Fialkowski 2007 Eastern Ave

DATE RECEIVED BY LOCAL REGISTRAR JUL 4 1949
REGISTRAR Washington Avenue, Md.

93D

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75920

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75920
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KATHERINE B. FREDERICK

2. DATE OF DEATH: 7-2-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Calvert 4335

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore: 77 YEARS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 10 12-01
D. STREET ADDRESS (If rural, give location): 100 WEST UNIVERSITY PARKWAY

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	SINGLE	7-26-1871	77	11 / 27	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	BALTIMORE	U.S.A.

13. FATHER'S NAME: GEORGE A. FREDERICK

14. MOTHER'S MAIDEN NAME: MARY EVERIST

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	No	NONE

17. INFORMANT: MRS. BEULAH HUNT — ADDRESS: 100 W. UNIVERSITY PARKWAY, BALT.

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA of STOMACH (CARDIAC PORTION
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
5-10-1949	HARD MASS NEAR CARDIAC END of STOMACH ANT. ON LESSER CURVATURE & POST SURFACE	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 4, 1949, to July 2, 1949, *that I last saw the deceased alive on* July 2, 1949, *and that death occurred at* 1.08 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Francis D. Ware M. D.	Union Memorial Hosp	7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 4 '49	Cathedral	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 4 1949	Thurlow Williams, M.D.	Stewart Moore	Balto.

VS 150

46 B

G75921

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75921 Registered No. 151

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John G. Kress

2. DATE OF DEATH: July 1-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2231 E. Pratt St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2231 E. Pratt St. 1-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Nov. 16-1901	47	7	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shipping Clerk	Sparrows Pt.	Balto. Md.	

13. FATHER'S NAME: Henry Kress

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	173-07-7852	Mary J. Kress	2231 E. Pratt St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF STOMACH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: SINCE APRIL 1948

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
AUG. 1948; MARCH 1949	CARCINOMA OF STOMACH WITH METASTASES	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/19, 1948 *to* 7/1, 1949 *that I last saw the deceased alive on* 7/1, 1949 *and that death occurred at* 11:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dorsey F. Drenga M. D.	209 N. Chester St.	July 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 5-49	St. Stanislaus Cem.	Dundalk Bx. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 4 1949	Washington Williams M.D.	John A. Miller	2334 Jefferson St

Write the cause of death clearly and legibly. Physician: please write the exact age if special. Important.

46B

CERTIFICATE CORRECTED 1-5-49 ✓ N 813.7 G75922

G75922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE FLOWERS N 813.7

2. DATE OF DEATH: July 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New Jersey
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jersey City
D. STREET ADDRESS (If rural, give location): 29 Jewett Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Feb 7, 1909	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	Commercial Painting	North Carolina	

13. FATHER'S NAME: William Flowers

14. MOTHER'S MAIDEN NAME: Mary Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no.		

17. INFORMANT: Evelyn Flowers. ADDRESS: 29 Jewett Ave. Jersey City N.J.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull
DUE TO
(B) Intracranial hemorrhage
DUE TO
(C) Contusion of brain.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street	U.S. Route #1, south of Little Gun Powder Falls, Kingsville

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 2, 1949 7 A. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Auto into pole

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 4, 1949	Family lot	Jersey City, N.J.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS: 1631 Druid Hill Ave 1702

G75923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. E 823.4 G75923

BIRTH NO. G75923

1. NAME OF DECEASED (Type or Print) RAY E. BROWN N-854.0

2. DATE OF DEATH July 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westminster
D. STREET ADDRESS (If rural, give location): 14 West Colonial Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Married	Aug 17 1916	32		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Produce dealer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carroll Co
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Edward P. Brown
14. MOTHER'S MAIDEN NAME: Jennie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Edward Dorsey ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subdural Hemorrhage
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Route 140 (near Sandy Mount, Westminster Pike)
21D. TIME (Month) (Day) (Year) (Hour): 7-3-49 -- 1:30 a. m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY occur?: Thrown from auto.when it ran off roadway

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: July 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 6-49
24C. NAME OF CEMETERY OR CREMATORY: Westminster
24D. LOCATION (City, town, or county) (State): Westminster Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 4 1949
REGISTRAR'S SIGNATURE: Pennington Williams, M.D.
25. FUNERAL DIRECTOR: J. Bankard Son ADDRESS: Westminster Md

170c

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

ES-129268

BIRTH NO. G75924

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75924

1. NAME OF DECEASED (Type or Print): Henry Kahler

2. DATE OF DEATH: 7-2-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: 74 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto. 26-06
D. STREET ADDRESS (If rural, give location): 6022 Elliot St. O'Donnell Heights.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	Under 1 Year: Months	Under 1 Year: Days	Under 24 Hours: Hours	Under 24 Hours: Min.
Male	White	Married	March 7, 1875	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Butcher	Md	

13. FATHER'S NAME: Conrad Kahler

14. MOTHER'S MAIDEN NAME: Anna Och

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

(Direct age is especially important. Physicians: please write the causes of death clearly and legibly.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-28, 19 49, *to* 7-2-, 19 49, *that I last saw the deceased alive on* 7-2- 19 49 *and that death occurred at* 12:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
O. S. Rogers M. D.	4940 Eastern Avenue	7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
BURIAL	7-5-49.	MT. CARMEL	O'DONNELL ST.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Thurlington Williams, M.D.	Charles S. Zeiler	901 S Conkling St

83B.

G75925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

31 G75925 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LILLIAN MARIE LORBER

2. DATE OF DEATH: July 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1919 W. Lexington St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1919 W. Lexington St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	Widowed	Aug. 10, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Baltimore	—

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Michael Trost	Catherine Stein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	Adolph Trost	843 W. Fayette St.

MEDICAL CERTIFICATION

(To be filled out by physician. If he has no knowledge of the facts, he will write the cause of death as reported to him by the coroner. Please write clearly and legibly. Incorrect age is especially important. Physician: please write the cause of death clearly and legibly.)

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
(A)	Cerebral Hemorrhage	4 hrs.
DUE TO		
(B)	Hypertension -	2 yrs.
DUE TO		
(C)	Congestive Heart Failure	48 hrs.

I — ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 1 1949, to July 1, 1949, *that I last saw the deceased alive on* July 1, 1949, *and that death occurred at* 7:20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles Martin Jr. M. D.	1933 W. Baltimore St.	7/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-4-49	Woodlawn	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 4 1949	Lexington Williams	George A. Farley - Fulton Ave. & Fayette St.	

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83a

G75926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 921.0 G75926 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BRENDA - L. LEWIS N-934.4

2. DATE OF DEATH July 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Mercy Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp.

C. Length of stay in Baltimore Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fulton, Md.
D. STREET ADDRESS (If rural, give location) Fulton, Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Single	Sept 12, 1947	22 months				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Stafford J. Lewis

14. MOTHER'S MAIDEN NAME Margaret Owen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) rupture of bifurcation of trachea following bronchoscopic examination	1 P.M July 3 to 1:45 P.M July 4, 1949
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) mediastinal & subcutaneous emphysema	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) foreign body (peanut?) in trachea	

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) accident

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Fulton, Md.

21D. TIME OF INJURY (Month) 7 (Day) 3 (Year) 49 (Hour) 1 P. m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21F. HOW DID INJURY OCCUR? while eating peanuts

22. I hereby certify that I attended the deceased from July 4, 1949 to July 4, 1949 that I last saw the deceased alive on July 4, 1949, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE Burton V. Lock MD

23B. ADDRESS Mercy Hosp. Balto Md.

23C. DATE SIGNED July 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 6/49

24C. NAME OF CEMETERY OR CREMATORY Greenfield

24D. LOCATION (City, town or county) (State) Laurel, Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 5 1949

REGISTRAR'S SIGNATURE [illegible]

25. FUNERAL DIRECTOR ADDRESS Wendell H. Donaldson

VS 150

1957

Please write the causes of death clearly and legibly. Physician: please write the exact age in especially important.

G75927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 900.1 G75927

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELIZABETH WIESNER Wiessner N-803.2

2. DATE OF DEATH July 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 422 South Anne Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. Life Mos. Days

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 1/10/1876
9. AGE (In years last birthday): 73 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? Roth

14. MOTHER'S MAIDEN NAME: Mary Burke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None

17. INFORMANT: Frank L. Koenig ADDRESS: 2309 Fleet St. Balto. Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull.
DUE TO
(B) Intracranial Hemorrhage.
DUE TO
(C) Contusion of brain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1722 Fleet Street (Fleet Inn) 2/3
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 30, 1949, 5:20 P.M.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fell down front steps while intoxicated

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE George S. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]
23C. DATE SIGNED: July 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/5/1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JUL 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Zeiler Inc. ADDRESS: 403 S. Wolfe St 31

HW 161

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

186a

CERTIFICATE CORRECTED 7-11-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 5928 (illegible) Registered No. G75928

1. NAME OF DECEASED (Type or Print) (illegible) ELLEN WELLS (MISS)

2. DATE OF DEATH 7-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland UNION MEMORIAL HOSP
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL
c. Length of stay in Baltimore 93 YEARS ENTIRE LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE, MARYLAND
D. STREET ADDRESS (If rural, give location) 1722 EAST LANVALE STREET

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	SINGLE	SEPT 8, 1865	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	MARYLAND	UNITED STATES

13. FATHER'S NAME: CAPTAIN DANIEL W. WELLS

14. MOTHER'S MAIDEN NAME: MARY C. SHIELDS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		Mrs William Dilling	Norfork Va.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		INTERVAL BETWEEN ONSET AND DEATH
	(A) HEART FAILURE	
	DUE TO	
ANTECEDENT CAUSES	(B) ARTERIOSCLEROSIS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERTROCHANTERIC FRACTURE, LEFT FEMUR	(178 DAYS) 6 MONTHS

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
JAN 6, 1949	PT PLACED IN WELL-LEE TRACTION	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
ACCIDENT	HOME	1722 E. LANVALE ST.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
JAN 6 1949 4 p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	FALL FROM LADDER 8/6

22. *I hereby certify that I attended the deceased from* JULY 1, 1949 *to* JULY 2, 1949, *that I last saw the deceased alive on* JULY 2, 1949, *and that death occurred at* 11 55 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William M. Lumbard M. D.	Union Memorial Hospital	3 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7/6/49	BALTIMORE CEM	BALTIMORE

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Hunter for Williams, M.D.	Charles H. Grandy Son Inc	118 W. Mt. Royal Ave 18

VS 150

Please write the cause of death clearly and correct age is especially important. Physicians: please write legibly.

G75929

BALTIMORE CITY HEALTH DEPARTMENT 443

CERTIFICATE OF DEATH

Registered No. G75929

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Richard C. Williams — 2. DATE OF DEATH 7-1-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Union Mem. Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. Length of stay in Baltimore 55 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3023 N. Calvert St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	Oct 16-1879	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Geologist	Geologist	Wordly. Md.	U. S. A.

13. FATHER'S NAME Thomas J. C. Williams

14. MOTHER'S MAIDEN NAME Cora M. Maddox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	Rose Delaney Williams	

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypertensive Cardiovascular	Unknown
	DUE TO (B) Disease	
ANTECEDENT CAUSES	Arteriosclerosis Generalized	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
Robert B. Mcgrodden M.D.		7-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State) ADDRESS
Burial	July 7/49	Dr Marks &	Lutherville, Bash. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 5 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John D. Mitchell Sons 1900 Eutaw Pl. 937

VS 151

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

CERTIFICATE CORRECTED 8-9-49

5930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75930

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Roland Benjamin

2. DATE OF DEATH July 1st 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 108 Witherspoon Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
* **********

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY Balto. Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
108 Witherspoon Road
D. STREET ADDRESS (If rural, give location)
108 Witherspoon Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	June 29 22.1884	65		1o

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Treasurer. Fidelity	Co. Fidelity Trust	Balto. Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Levi Benjamin	Mollie Beckwith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		Roland Benjamin Jr. 108 Wotherspoon Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis (bony metastases) — INTERVAL BETWEEN ONSET AND DEATH: detected 4 mos

DUE TO

(B) Carcinoma of lung — 5 months +

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 2nd, 1949 *to* July 1st, 1949 *that I last saw the deceased alive on* June 30, 1949, *and that death occurred at* 8:30 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis P. Hamburger M. D.	1207 Eutaw Place	7/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 5.1949	Greenmount Cemetery	Greenmount Ave. Oliver St

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 5 1949	Huntington Williams M.D.	John O. Mitchell & Sons 1900 Eutaw Place

John O. Mitchell

VS 150

Dr. Hamburger 1207 Eutaw Place

47D

...ct age is especially important. Physician: please write the cause of death clearly and fully.

G75931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75931

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Louis BARRIS

2. DATE OF DEATH 7-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Mount Sinai

C. Length of stay in Baltimore 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-04
D. STREET ADDRESS (If rural, give location) 2019 Ruxton Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) (Last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed		75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Russia	

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Rose Wolfert	2019 Ruxton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO Arteriosclerosis & generalized

(B) Myocarditis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 7/2/49.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 29 1949, to July 5, 1949, *that I last saw the deceased alive on* July 5, 1949, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	M. D.	23B. ADDRESS	23C. DATE SIGNED
W. C. Veeder		814 - W. North Ave	7-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-5-49	Bnai Israel	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	[illegible] Williams, M.D.	Jack Lewis Inc 2100	Eutaw Pl

VS 150

937

Please write the cause of death clearly and correct age is especially important. Physician please write

675932

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 675932

Registered No.

1. NAME OF DECEASED (Type or Print) HYMAN NOAH SHATKIN

2. DATE OF DEATH 7-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2240 Eutaw Place

C. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-03
D. STREET ADDRESS (If rural, give location) 2240 Eutaw Place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married		81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Russia	

13. FATHER'S NAME
Benzion

14. MOTHER'S MAIDEN NAME
Henda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Rose Shatkin	2240 Eutaw Pl

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia (Terminal) — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Carcinoma of Lung (Rt) — 2 years

DUE TO

(C) Diabetes Mellitus — 5 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/6 1949 *to* 7/4 1949, *that I last saw the deceased alive on* 7/4 1949, *and that death occurred at* 1P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	2320 Eutaw Pl	7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-5-49	Mishkan Israel	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	Jack Lewis Jr	2100 Eutaw Pl

VS 150

47D

Please write the cause of death clearly and legibly. Physician: please write exact age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 25933 — Registered No. 25933

1. NAME OF DECEASED (Type or Print): Jacob Dackman

2. DATE OF DEATH: 7-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3906 Chatham Rd
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 15-19
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3906 Chatham Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M		66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Real Estate		Russia	

13. FATHER'S NAME: Jacob

14. MOTHER'S MAIDEN NAME: Hannah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Minnie Dackman — ADDRESS: 3906 Chatham

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inquest (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Robert B. McFadden, M.D. — 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ — 23C. DATE SIGNED: 7-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-5-49	Beth Tfiloh	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 5 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Jack Lewis Inc — ADDRESS: 2100 Eutaw Pl.

VS 151

94a

Cause of death clearly and legibly. Physician: please write the exact age is especially important.

675934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

675934 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elsie L. Wirth

2. DATE OF DEATH July 4th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3413 Guilford Terrace

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3413 Guilford Terrace

C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3413 Guilford Terrace

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
f	W	Single	May 12,1889	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Teacher, retired	Balto City Schools	Baltimore, Md.	

13. FATHER'S NAME: Andrew Wirth

14. MOTHER'S MAIDEN NAME: Marguerite Baals

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	Miss Marguerite B. Wirth, 3413 Guilford Terrace

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — DUE TO

ANTECEDENT CAUSES

(B) — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Insp & Inq (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE William J. Helbrecht M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED July 4-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/6/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 5 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

937

G75935

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75935

1. NAME OF DECEASED (Type or Print) MARY ALVINA GUTHRIDGE

2. DATE OF DEATH 7/4/49

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE MD

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2701 WOODSDALE AVE

c. Length of stay in Baltimore 56 YRS. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2701 WOODSDALE 7-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F.	W.	WIDOWED	JAN. 8 1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HW

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MARTINSBURG W. VA.

12. CITIZEN OF WHAT COUNTRY? AMERICA

13. FATHER'S NAME CHARLES ERNST

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT SON ADDRESS 2701 WOODSDALE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: JULY 4 49

DUE TO

(B) DIABETES MELLITUS — 1939

DUE TO

(C) HYPERTENSION — 1939

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE: (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location).

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from June 24 1949 to July 4, 1949, that I last saw the deceased alive on July 2, 1949 and that death occurred at 7:50 A m., from the causes and on the date stated above.

23A. SIGNATURE Walter E. Harbin M. D.

23B. ADDRESS 4331 Harford Rd

23C. DATE SIGNED 7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/7/49

24C. NAME OF CEMETERY OR CREMATORY Edgehill

24D. LOCATION (City, town, or county) Brooklyn MD (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 8 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wilson Conf. Sons

ADDRESS 1101 Pennsylvania Ave

VS 150

61

Please write the cause of death clearly and legibly. Physician: please write the correct age in especially important.

AB-121215

75936

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75936

1. NAME OF DECEASED (Type or Print) Charles Lewis

2. DATE OF DEATH July 2-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals
4940 Eastern Avenue

c. Length of stay in Baltimore: Life (Yrs. / Mon. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-12
D. STREET ADDRESS (If rural, give location) Baltimore City Hospitals(Infirmary

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Single	Aug. 3- 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher

10B. KIND OF BUSINESS OR INDUSTRY Public [illegible]

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Lewis

14. MOTHER'S MAIDEN NAME Mary Caskey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Baltimore City Hospitals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Leukemia	
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO XXX

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-13, 1948, *to* 7-2, 1949 *that I last saw the deceased alive on* 7-2, 1949, *and that death occurred at* 10.20P m., *from the causes and on the date stated above.*

23A. SIGNATURE H. S. Rogers M. D. | 23B. ADDRESS Baltimore City Hospitals | 23C. DATE SIGNED 7-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/6/49	Cedar Hill	Brooklyn, Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 5 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wilson Co. | ADDRESS: 1217 N. Paul St

VS 150

74a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

75937

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163

G75937

Registered No.

1. NAME OF DECEASED (Type or Print) ARTHUR E. KIDWELL

2. DATE OF DEATH JULY 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4906 HARFORD ROAD
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE.
D. STREET ADDRESS (If rural, give location) 4906 HARFORD ROAD.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
MALE	WHITE	MARRIED	SEPT. 11, 1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	******	BALTO. MD.	

13. FATHER'S NAME: GEORGE T. KIDWELL

14. MOTHER'S MAIDEN NAME: SARAH A. HARPER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	NONE	MISS MARGUERITE E. KIDWELL	4906 HARFORD RD.

MEDICAL CERTIFICATION — Please write the cause of death clearly and legibly. Physician: please write the correct age in especially important.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic cardiac + arteriosclerosis

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 1948 *to* July 1949, *that I last saw the deceased alive on* July 2, 1949, *and that death occurred at* 12:30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	4219 Talbot Rd.	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	JULY 5, 1949	LOUDON PARK CEMETERY	BALTIMORE, MARYLAND.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JUL 5 1949	Huntington Williams, M.D.	WILLIAM J. TICKNER & SONS, NORTH & PA. AVES. BALTO. MD.

VS 150

477

G75938

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75938

1. NAME OF DECEASED (Type or Print): MONTGOMERY LAWRENCE BOLSTER

2. DATE OF DEATH: 6/30/49

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 8 Mallow Hill Ave

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 8/2/1888
9. AGE (In years last birthday): 60
If under 1 Year: Months / Days
If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Wholesale Furniture

11. BIRTHPLACE (State or foreign country): Md. (Baltimore)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Bolster
14. MOTHER'S MAIDEN NAME: Ella Cruser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: Mrs. Christina Bolster--8 Mallow Hill Rd

MEDICAL CERTIFICATION

(Please write the cause of death clearly and correct age is especially important. Physician:)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MASSIVE G. I. HEMORRHAGE

DUE TO

(B) CIRRHOSIS OF LIVER &
DUE TO ESOPHAGEAL VARICES

(C) TERMINAL URAEMIA

ANTECEDENT CAUSES - DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS - CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/29, 1949, *to* 6/30, 1949 *that I last saw the deceased alive on* 6/30, 1949, *and that death occurred at* 2:20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: John W. Shaw M. D.
23B. ADDRESS: St. Agnes Hosp.
23C. DATE SIGNED: 6/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/5/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

124B

G75939 ~~B-129268~~ 129989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

00 G75939 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Wiley Hodge

2. DATE OF DEATH: 7-1-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: 5 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 648 W. Lee Street.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Single	June 21, 1930	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		S.C.	

13. FATHER'S NAME: Alonza Hodge

14. MOTHER'S MAIDEN NAME: Maggie Caroline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

Direct age is especially important. Physicians: please write the causes of death clearly and legibly

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Far Advanced Pulmonary Tuberculosis	4 Mos.
	DUE TO (B)	
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-29 ; 19 49 ; *to* 7-1 , 19 49 , *that I last saw the deceased alive on* 7-1 1949 , *and that death occurred at* 4:40 Pm., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	4940 Eastern Avenue	7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 4-49	Mt Auburn	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	James A. Hayes	142 W. Hill St

VS 150

13B

675940

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

675940

Registered No.

1. NAME OF DECEASED (Type or Print): Josefa (Sophie) Kaspar

2. DATE OF DEATH: July 3,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — 1224 N. Patterson Pk Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: 1 224 N. Patterson Pk Ave.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
d. STREET ADDRESS (If rural, give location): 907

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widow	May 22,1874	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife at home		Baltimore, Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		nonw	Regina Freitag	1224 N. Patterson Pk Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 9 mos

DUE TO

(B) Carcinoma of Stomach

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: arteriosclerotic CVD

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME—(Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 1948 *to* 7/3 1949, *that I last saw the deceased alive on* 7/3 1949 *and that death occurred at* 4:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Stanley B. Klyszewicz M. D.	3500 Gorman Ave	7/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/6/49	Holy Redeemer Cemetery.	Belair Road.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	Schimunek Funeral Home Inc.	2601 E. Madison

VS 150

46B

Please write the cause of death clearly and correct age is especially important. Physician: please write the

B.C.# 49-13796

675941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176 675941 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Baby Boy Putschky

2. DATE OF DEATH 7-1-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5-04

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 400 Jack Street

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 7-1-49 | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours 6 Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Putschky | 14. MOTHER'S MAIDEN NAME Marie Disisa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

(Please write the cause of death clearly and correct age is especially important. Physician:

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia

DUE TO

(B) Cardiac decompensation of Myocarditis.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/1, 19 49 *to* 7/1, 19 49 *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE C. Rohrbaugh M. D. | 23B. ADDRESS St. Agnes Hosp. | 23C. DATE SIGNED 7/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify) B. | 24B. DATE 7-5-49 | 24C. NAME OF CEMETERY OR CREMATORY Edon Hill | 24D. LOCATION (City, town, or county) Brooklyn. (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 5 1949 | REGISTRAR'S SIGNATURE Justina for Williams, M.D. | 25. FUNERAL DIRECTOR Jos. Lee Carey | ADDRESS 1305 Fort Ave. 159

VS 150

G75942
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1948 G75942
Registered No.

1. NAME OF DECEASED (Type or Print): OSBOLNE B. UPPERQUE
2. DATE OF DEATH: 3 July 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto Gen Hosp
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 350 Keswick Rd 3106

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		Jan 12 1907	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chicken Inspector	York motors	Maryland	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm. H. Upperque	Nellie M. Marsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Freda A. Upperque	3501 Keswick Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Generalized Carcinomatosis Primary site of lung undetermined	9-12 mos
ANTECEDENT CAUSES (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Hypertension	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 1949 *to* July 2, 1949, *that I last saw the deceased alive on* July 2, 1949, *and that death occurred at* 6:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph Shea M. D.	West Balto Gen Hosp	7/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	July 6/49	St. Mary's Hampden	Roland Ave, Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 [illegible]	Huntington Williams, M.D.	Euston E. Bowman	3816 Roland Ave

VS 150

55E

Write clearly and legibly. Physician: please write the cause of death clearly and legibly. Be exact age is especially important.

G75943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75943 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary C.Hogan

2. DATE OF DEATH: July 5th.,1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3907 Bateman Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 3907 Bateman Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Feb,5th.,1872	77	5	0		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher (Retired)

10B. KIND OF BUSINESS OR INDUSTRY: Balto:City

11. BIRTHPLACE (State or foreign country): Baltimore,Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Hogan

14. MOTHER'S MAIDEN NAME: Mary Moran

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Mr. John W.Hogan,3907 Bateman Avenue (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho-Pneumonia

DUE TO

(B) Hemiplegia

DUE TO

(C) Cerebral Haemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1949 *to* July, 1949 *that I last saw the deceased alive on* July 1st, 1949 *and that death occurred at* 4:4 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D. | 23B. ADDRESS: 1E. Ramsay St. | 23C. DATE SIGNED: 7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 7-9-49 | 24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetary | 24D. LOCATION (City, town, or county) (State): Edmondson Ave.Balto:Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 5 1949 | REGISTRAR'S SIGNATURE: [signature] | 25. FUNERAL DIRECTOR: George J.Ruth,Inc. | ADDRESS: 1935 Harford Avenue

VS 150

83a

G75944
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75944
Registered No.

1. NAME OF DECEASED (Type or Print) Mary Owens — 2. DATE OF DEATH 7/2/49

3. PLACE OF DEATH: a. Baltimore City, Maryland — b. (If not in hospital or institution, give street address or location) 818 N. Calhoun St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE South Carolina — b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

d. STREET ADDRESS (If rural, give location) 16-2

8. FULL NAME OF HOSPITAL OR INSTITUTION Balto. Md.

c. Length of stay in Baltimore 6 yrs. (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F	Col.	married	1896	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic — 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) S. C. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Samuel Green — 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.

17. INFORMANT Robert Owens — ADDRESS 163 Eutaw St Hanover Comm.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L. Rogers M.D. — 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ — 23C. DATE SIGNED 7-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE 7/7/49 — 24C. NAME OF CEMETERY OR CREMATORY — 24D. LOCATION (City, town, or county) (State) Americus, Ga.

DATE RECEIVED BY LOCAL REGISTRAR JUL 5 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR 927 Monument ADDRESS Metropolitan Funeral Home Inc.

VS 151

937

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75945

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Maties Putschky

2. DATE OF DEATH July 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland St. Agnes Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital.

c. Length of stay in Baltimore 31 Yrs. / More Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 400 Jack Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	MARRIED	7/17/17	31		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Michael Disaia

14. MOTHER'S MAIDEN NAME Barbara

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO	—	NONE

17. INFORMANT ADDRESS JOHN W. PUTSCHKY 400 JACK ST.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Decompensation

DUE TO Rheumatic Heart Disease Grade IV

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pregnancy — Delivered (2 wks)

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 30 June, 1949 *to* 2 July, 1949 *that I last saw the deceased alive on* 2 July, 1949, *and that death occurred at* 10:30 P *m., from the cause and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. H. O'Elia Jr. M. D.	St. Agnes Hosp	3 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	JULY 6 1949	HOLY REDEEMER	4430 BELAIR RD MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Washington Williams, M.D.	Duffel Bros.	1800 E LOMBARD ST.

VS 150

95B

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G75946
ES-130047
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
43 G75946 Registered No.

1. NAME OF DECEASED (Type or Print): Thomas Carter
2. DATE OF DEATH: 7-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
c. Length of stay in Baltimore: 20 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If Institution; residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1125 Race Street.

23-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 1 Day: Hours / Min.
Male	Negro	Married	July 4, 1900	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		S.C.	

13. FATHER'S NAME: Henry Carter
14. MOTHER'S MAIDEN NAME: Mary Porter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S ADDRESS
		Records- Baltimore City Hospitals 4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 Yrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-2- 19 49, *to* 7-3- 19 49, *that I last saw the deceased alive on* 7-3- 19 49 *and that death occurred at* 9:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. A. Rogers M. D.	4940 Eastern Avenue	7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/6/49	Rockhill	S. C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Washington Williams, M.D.	L. L. Brown & Co.	109 W. Montgomery St.

VS 150

937

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75947

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 48-19376

CERTIFICATE OF DEATH

85.0

Registered No. G75947

1. NAME OF DECEASED (Type or Print) Barbara Ann Miller

2. DATE OF DEATH 7-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Provident Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hosp. 1514 Division St.

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 1204 Penn. Ave. City

D. STREET ADDRESS (If rural, give location) 1204 Penn. Ave. 17-0 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Single	Aug 7, 1948	9/12 Yrs.	10 / 27	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployable		Baltimore, Md.	U. S.

13. FATHER'S NAME George Miller

14. MOTHER'S MAIDEN NAME Margaret Mc Clelland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Hospital Record.	✓

MEDICAL CERTIFICATION

(Correct age is especially important. Physician: please write the causes of death clearly and legibly.)

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Encephalitis (Post-infectious) — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Measles

DUE TO

(C) Rubella (Rubeola)

over

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	No	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-2, 1949, *to* 7-3, 1949, *that I last saw the deceased alive on* 7-3-, 1949 *and that death occurred at* 10 1/2 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L E Brady M. D.	Provident Hospital	7-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-5-49	Mt Auburn Cem	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	Mc Spearman & Hensley	N Bond St

VS 150

35

G75948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75948

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles Wm. Mahn - MAHN

2. DATE OF DEATH 4 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital
c. Length of stay in Baltimore 67 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3700 Grantley Rd 15 11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	19 Nov 1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ass't. Chief Clerk	Railroad	Baltimore, Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Mahn	Amelia Denninger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Mrs. Elizabeth E. Mahn - 3700 Grantley Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary artery disease	20 yrs
ANTECEDENT CAUSES	DUE TO (B) Generalized arterio-sclerotic Cardio-vascular disease.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Rheumatoid arthritis Chronic interstitial heart failure	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3 July *1949, to* 4 July *, 1949, that I last saw the deceased alive on* 4 July *, 1949, and that death occurred at* 6 30 Pm., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. F. Coe 3rd M. D.	Union Memorial Hospital	4 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/6/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

93c

G75949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33 G75949

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ROSA PEARCE GILMORE

2. DATE OF DEATH 7-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balt.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore 66 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 218 E. 22nd St. 1204

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
F	W	widowed	Sept. 1, 1882	66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore Md.	USA

13. FATHER'S NAME Mr. John Pearce

14. MOTHER'S MAIDEN NAME Katherine Gaunt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	Mr. Ellis G. Gilmore	721 Argonne Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) arteriosclerosis & hypertension — 2 yrs. +

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 29, 1949 *to* July 4, 1949 *that I last saw the deceased alive on* July 3, 1949 *and that death occurred at* 7:40 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank R. Ziegler III M. D.	Union Memorial Hospital	7/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/7/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Thurlington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

83B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 98 5

Registered No. G75950

BIRTH NO. W-25950

1. NAME OF DECEASED (Type or Print): Richard Earl Smith — N-861-2

2. DATE OF DEATH: July 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 404 N. Green St. 12-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
M	W	SINGLE	4/12/1928	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ernest Smith
14. MOTHER'S MAIDEN NAME: Irene Gray
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW-II
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Ellen Gray — ADDRESS: 2915 S. Wolfe St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Stab-wound of lung and heart.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Fremont & Baltimore St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 4, 1949 2 A m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Sharp instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: George A. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: July 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/7/49
24C. NAME OF CEMETERY OR CREMATORY: Balto. National
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Zeiler — ADDRESS: 403 S. Wolfe St.

VS 151

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

167

G759-51 100412

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75951

1. NAME OF DECEASED (Type or Print) Gertrude Jackson

2. DATE OF DEATH 7-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore 20 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) altimore
D. STREET ADDRESS (If rural, give location) 1106 N. Mount St. 16-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Negro	Single	March 10, 1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Va.	

13. FATHER'S NAME Ellis Jackson

14. MOTHER'S MAIDEN NAME Molly ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		B. C. H. Records,	4940 Eastern Ave.

MEDICAL CERTIFICATION

Please write the cause of death clearly and correct age is especially important. Physician: please

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(B) Cerebral Vascular Accident — 1 week
DUE TO
(C) Hypertensive Arteriosclerotic Cardio-Vascular Disease — 10 Yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-5-46, 19__, *to* July 1, 19 49 *that I last saw the deceased alive on* July 1, 19 49, *and that death occurred at* 6.10 AM., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[illegible] M. D.	4940 astern Ave.	7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 5-49	Mt. Auburn	Balto City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	George Nelson	1303 Jeff. [illegible]

VS 150

937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

675952 BIRTH NO. — Registered No. 675952

1. NAME OF DECEASED (Type or Print): Agnes Sliwka (Plum) Agnes Sliwka — 2. DATE OF DEATH: July 2nd 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hosp DOA
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Durham Street
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 951 S. Durham St. 202

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year, last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
F	W	Married		64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Poland	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Joseph Sliwka	

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial degeneration
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: William S. Selbert M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: July 2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/6/49	Holy Rosary Cem	German Hill Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	Mary Weber	401 S. Chester St.

VS 151

93D

Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

G75953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75953

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Wallace Cornish

2. DATE OF DEATH: July 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.G. Johns Hopkins Hosp

C. Length of stay in Baltimore: 1920 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1023 N. Bond St T-64

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 12 1898
9. AGE (in years last birthday): 50 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cambridge, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Cornish
14. MOTHER'S MAIDEN NAME: Annie Cornish

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.

17. INFORMANT: Mary Lewis ADDRESS: 1023 N. Bond

MEDICAL CERTIFICATION

(Physician: please write the cause of death clearly and legibly. Correct age is especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: July 3 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 7 49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): BA County Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mrs Robt A. Edwards & Son
ADDRESS: 937 1297 N. Carlton St

VS 151

G75954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75954

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE KEAD PURCELL

2. DATE OF DEATH JULY 4 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5506 BELLVILLE AVE., BALTO. 7, Md

c. Length of stay in Baltimore 76 YEARS Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 5506 BELLVILLE AVE.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If over 1 year last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	JAN. 11, 1873	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FOREMAN	STONE CONSTUCTION WORK	MARYLAND	U.S.A.

13. FATHER'S NAME: GEORGE K. PURCELL

14. MOTHER'S MAIDEN NAME: MARY WHITE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	WIFE - MRS. PURCELL	Emma Carns 5506 BELLVILLE AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) LYMPHOSARCOMA.	15 MONTHS
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
APRIL 24 1949	LYMPHOSARCOMA.	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* MAY 29, 1949, to JULY 4, 1949, *that I last saw the deceased alive on* JUNE 3, 1949, *and that death occurred at* 2:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edwin Thurston M. D.	7017 LIBERTY RD. BALTO. 7, Md.	JULY 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 7, 1949	Woodlawn Cemetery	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	Wells Lamoreau	4510 Liberty Heights Ave.

VS 150

55E

Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

CERTIFICATE CORRECTED 2-6-39

G75955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75955
Registered No. 33264

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John H. Dietrich ~~Dieterich~~

2. DATE OF DEATH 7-3-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital
C. Length of stay in Baltimore Life Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore (Catonsville) 28-1
D. STREET ADDRESS (If rural, give location) 5515 ~~E. Lake Ave~~ Elderon Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	widowed	4-12-1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Barber
10B. KIND OF BUSINESS OR INDUSTRY Self.
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles W. ~~Dieterich~~ Dietrich
14. MOTHER'S MAIDEN NAME Elizabeth Ernest
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mr. Charles W. Dietrich Son ADDRESS Catonsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 3 August Ave Catonsville Md

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIO SCLEROTIC CARDIO-

DUE TO

(B) VASCULAR DISEASE E GRADE III DECOMPENSATION

DUE TO

(C) MYOCARDIAL INFARCTION TERMINAL UREMIA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [4] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7/1, 1949 *to* 7/3, 1949, *that I last saw the deceased alive on* 7/2, 1949, *and that death occurred at* 1:25 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John B. Shaw M. D.	45 Agnes Hosp.	7/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 6 1949	Mt Manuel Cem.	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams M.D.	J. Wells Lawrason	4510 Liberty Hgts Ave

VS 150

93D

Please write the cause of death clearly and correct age is especially important. Physician:

G75956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75956

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE E. TAYLOR

2. DATE OF DEATH June 30, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1023 Carrollton Street

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 1203 Smithson Street 16-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored		May 30, 1900	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Va	

13. FATHER'S NAME Lewlyn Mercer

14. MOTHER'S MAIDEN NAME Marthe Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	W.W. I.	218-10-3615	Mary Boyens	3736 Filbert St. Phila.Pa

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		7-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 5, 1949	Balto nat cem.	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	George G. Kelson	1303 Presstman St

94a

Please write the cause of death clearly and forcibly. Physician: please write: correct age is especially important.

G75957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G75957

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANZIE HALL

2. DATE OF DEATH: June 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1212 W. Lexington Street

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1212 W. Lexington Street 18

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Widow	Dec. 25, 1878	70 71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Dale, Virginia	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Dennis Hall.	1618 Baltimore Court

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic Cardio.	
	DUE TO Vascular Disease	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
II	(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER, ASSISTANT MEDICAL EXAMINER, MEDICAL INVESTIGATOR	23C. DATE SIGNED
Hillman J. McClafferty M.D.	☒	7-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	7/5/49	W. F. Chatsworth Cem.	Balto.	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	Mrs Katie R. Williams	822 N. Schroeder St.

VS 151

93)

Please write the cause of death clearly and legibly. Physician: please write correct age is especially important.

G75958

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 33

G75958

Registered No.

1. NAME OF DECEASED (Type or Print) Rose O. Jenkins

2. DATE OF DEATH 7/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3410 Toone St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 81 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) B alto.
D. STREET ADDRESS (If rural, give location) 3410 Toone St. 26-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	White	widow	Oct.10,1867	81	8 / 23	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Benjamin Davis

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Gladys Jenkins ADDRESS 3410 Toone St.

MEDICAL CERTIFICATION

Effect age is especially important. Physician: please write the cause of death clearly and fully.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 1 WK.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ARTERIOSCLEROSIS GENERAL — 10 yrs.

DUE TO

(C) HYPERTENSION — 10 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* FEBRUARY 1 1949 *to* JULY 2 1949, *that I last saw the deceased alive on* JULY 1 1949 *and that death occurred at* 4:15 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE Hermann Hofstein M. D.

23B. ADDRESS 121 S. HIGHLAND AVE

23C. DATE SIGNED JULY 2 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/6/49

24C. NAME OF CEMETERY OR CREMATORY Baltimore

24D. LOCATION (City, town, or county) (State) North Ave & Rose St.

DATE RECEIVED BY LOCAL REGISTRAR JUL 5 1949

REGISTRAR'S SIGNATURE Temistocles Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Clarence F. Hoffmann 1639 Broadway.

VS 150

83a

G75959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63

G75959

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Arthur M. White

2. DATE OF DEATH July 3,1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 4620 O'Donnell St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 70 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 4620 O'Donnell St. 26-06

5. SEX M

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH Dec.10,1878

9. AGE (In years last birthday) 70 (If under 1 Year: Months 6, Days 24; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) B alto. Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Wm. H. White

14. MOTHER'S MAIDEN NAME Elizabeth Knight

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Sister ADDRESS Mrs. Webb 4620 O'Donnell St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchial Pneumonia

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* 5/14, 1949 *to* 7/3, 1949, *that I last saw the deceased alive on* 7/2, 1949, *and that death occurred at* 12:40 m., *from the causes and on the date stated above.*

23A. SIGNATURE Chas F Flom M. D.

23B. ADDRESS 3123 Eastern Ave

23C. DATE SIGNED 7/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/7/49

24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel

24D. LOCATION (City, town, or county) (State) O'Donnell St

DATE RECEIVED BY LOCAL REGISTRAR JUL 5 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Clarence F. Hoffmann 1639 Broadway

VS 150

47c

Write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

BIRTH NO. G75960 130958

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 Registered No. G75960

1. NAME OF DECEASED (Type or Print) Margaret Fitzsimmons

2. DATE OF DEATH July 3- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2301 Maryland Ave. 1206

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	S ingle	? ? ?	70 ?				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		?	

13. FATHER'S NAME
?

14. MOTHER'S MAIDEN NAME
?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT B.C.H. Records ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

(Correct age is especially important. Physician: please write the cause of death clearly and legibly.)

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral vascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 48hrs.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES XX NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7- 3- , 1949 *to* 7- 3- , 1949 *that I last saw the deceased alive on* 7- 3- , 1949 *and that death occurred at* 11.30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
P. S. Rogers M. D.	4940 Eastern Ave.	7- 4- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/6/49	Cathedral	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 5 1949	Huntington Williams, M.D.	H. H. Mears & Son, 805 N. Calvert St.

VS 150

83a

G75961

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

Registered No. G75961

1. NAME OF DECEASED (Type or Print): Ruby Laws

2. DATE OF DEATH: July 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1109 Springfield Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 27-09 1109 Springfield Ave.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Juky 7,1876
9. AGE (In years last birthday): 73 Yrs
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lancaster. Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Cruthfield
14. MOTHER'S MAIDEN NAME: Elizebeth Luckem

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS: Mrs. Janet Colby-1109 Springfield Ave

MEDICAL CERTIFICATION

Write the cause of death clearly and correct age is especially important. Physician: please write this

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7/3/49
DUE TO
(B) Hypertension & arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/13, 19 49, *to* 7/03, 19 49 *that I last saw the deceased alive on* 7/3/49, 19___, *and that death occurred at* ___ m. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1131 Harlem Avenue
23C. DATE SIGNED: 7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 7, 1949
24C. NAME OF CEMETERY OR CREMATORY: Family Lot
24D. LOCATION (City, town, or county) (State): Lively-Lancaster Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 5 1949
REGISTRAR'S SIGNATURE: [signature] Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Holland Funeral Home-1631 Druid Hill Ave.

VS 150

83a

G75962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75962

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Adelle Johnson

2. DATE OF DEATH July 3, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 431 N. Calhoun St. 1901

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore 16 Yrs. (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	Mar. 8, 1903	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Darlington, S. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Amiel Weston

14. MOTHER'S MAIDEN NAME: Elvira Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: William C. Johnson ADDRESS: 431 N. Calhoun St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18.

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Rt ovary with metastasis to left oviduct - broad ligaments & Carcinomatosis (abdomen)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 5/19/49

19B. MAJOR FINDINGS OF OPERATION above findings

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/16 *, 19*49 *to* 7/3 *, 19*49 *that I last saw the deceased alive on* 7/3/49 *, and that death occurred at* 2:00 a m. *from the causes and on the date stated above.*

23A. SIGNATURE H. C. Welcome M. D.

23B. ADDRESS 1131 Harlem Avenue

23C. DATE SIGNED 7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 6, 1949

24C. NAME OF CEMETERY OR CREMATORY: Balto. Nat'l Cem.

24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 5 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS: 1631 Druid Hill Ave.

VS 150

49a

Please write the cause of death clearly and correct age is especially important. Physician: please write this

G75963

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75963

1. NAME OF DECEASED (Type or Print) Grooms, Annie

2. DATE OF DEATH 7/5/99

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1519 Division Str.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-14
D. STREET ADDRESS (If rural, give location) 306 Hoffman Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Negro	Widowed	1860	89				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Washington, D.C.	

13. FATHER'S NAME —

14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT —	ADDRESS

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Failure

DUE TO

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

(C) Uremia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Carcinoma of Stomach

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/28, 1999 *to* 7/5, 1999, *that I last saw the deceased alive on* 7/5/99 *and that death occurred at* 8:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr Marcus W. Moore Sr. M.D.	Provident Hospital	7/5/99

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/7/99	Balto. Nat'l Cem.	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1999	Huntington Williams, M.D.	Holland Funeral Home	1631 D.H.B.

VS 150

46B

G75964

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

63

G75964

Registered No.

1. NAME OF DECEASED (Type or Print) John T. Liston

2. DATE OF DEATH July 3-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1607 Jackson St

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1607 Jackson St. Balto. Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md.
D. STREET ADDRESS (If rural, give location) 1607 Jackson St. 24-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Married.		77				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Pittsburg Pa.	

13. FATHER'S NAME Michael Liston

14. MOTHER'S MAIDEN NAME Nora Mulvihill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS
Agnes M. Liston 1607 Jackson St.

MEDICAL CERTIFICATION

Write the cause of death clearly and correct age is especially important. Physician: please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH Undetermined

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Feb. 19 49 *to* June, 1949, *that I last saw the deceased alive on* June 20, 1949 *and that death occurred at* 0 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R Ellison M. D.	107 E. West St	7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 7-1949	Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	Flynn & Fleming	1426 Light St.

479

G75965

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170 ✓ X G75965 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES HALL

2. DATE OF DEATH 7/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) PROVIDENT HOSPITAL
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 516 S GREEN ST 22-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	N	S	3-4-1890	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TAILOR		MD	USA

13. FATHER'S NAME UNKNOWN

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	217-07-8976	DECEASED	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) GENERALIZED CARCINOMATOSIS
DUE TO
(B) METASTASIS FROM PROBABLE
DUE TO PRIMARY CA OF RT. BREAST.
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTIC HT. DISEASE

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-20, 1949 *to* 7-2, 1949, *that I last saw the deceased alive on* 7-2, 1949, *and that death occurred at* 5:20 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	Provident Hospital	7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Mt. Auburn Cemetery	Balto - Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	Walter B. Young	32 Walbrook St.

VS 150

50

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75966

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3-3

G75966

Registered No.

1. NAME OF DECEASED (Type or Print): Russell Watkins

2. DATE OF DEATH: 7/4/49

3. PLACE OF DEATH: a. Baltimore City, Maryland — Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3819 Edmondson Ave — 20-07

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	April 15, 1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
(Retired Plumber	Railroad	Maryland (Balto.)	

13. FATHER'S NAME: Cornelius Watkins

14. MOTHER'S MAIDEN NAME: Ida May Merson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Mrs. Bessie A. Watkins	3819 Edmondson Av

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician, please write the exact age is especially important.)

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/28, 1949, *to* 7/4, 1949, *that I last saw the deceased alive on* 7/4, 1949, *and that death occurred at* 7 15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. D. Dani M. D.	West Balto Gen Hosp	7-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/7/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, MD	WM. J. TICKNER & SONS	Balto., Md.

VS 150

83a

G75967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75967

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Fannie Greenwald,**

2. DATE OF DEATH **July 5, 1949**

3. PLACE OF DEATH: Baltimore City, Maryland **Balto.Md.**

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Esplanade Apts.**

c. Length of stay in Baltimore **Lifetime,** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE **Esplanade Aprt. City.** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) **Espanade Aprt. City.** 13-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widow	Aug.3rd.1859.	89	11	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Balto.Md.	

13. FATHER'S NAME **Isaac Hamburger,**

14. MOTHER'S MAIDEN NAME **Bettie Hamburger**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT **Dr.Irving J.Spear** ADDRESS **928 N.Charles**

MEDICAL CERTIFICATION

Write the cause of death clearly and forcibly. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cerebral Thrombosis** — INTERVAL BETWEEN ONSET AND DEATH: **4 days**

DUE TO

(B) **Generalized arteriosclerosis**

DUE TO

(C) **Diabetes Mellitus**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. **Hypostatic Pneumonia** — **One Month**

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* **April** 1949, *to* **July 4**, 1949, *that I last saw the deceased alive on* **July 4**, 1949, *and that death occurred at* **5:15** a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis H. Cohen M. D.	**5901 Park Heights Ave**	**7/5/49**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**July 5th.1949.**	**Hebrew Friendship Cem,**	**Balto.Md.**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	**Robert Goodman**	**1902 Eutaw Pl**

VS 150

61

G75968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

G75968

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Vincent Zappa

2. DATE OF DEATH July 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Jenkin's Mem. Hosp
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jenkin's Memorial Hospital, Baltimore
c. Length of stay in Baltimore Yrs. Mos. Days 27-10

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Jenkin's Memorial Hospital
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md.
D. STREET ADDRESS (If rural, give location) 5217 York Road, Baltimore

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If less than 1 year, last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	7/19/1875	73		

10A. USUAL OCCUPATION (Give kind of work done during largest part of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Italy	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Francis Zappa	Margaret

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Jos. Zappa	521 Tunbridge Rd

MEDICAL CERTIFICATION — Physician please write the cause of death clearly and legibly. Be sure correct age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HYPERTENSIVE CARDIO VASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: -

DUE TO

(B) CEREBRAL HEMORRHAGE (L HEMIPLEGIA IN CLEFT) —

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from April, 1947 to July 3, 1949, that I last saw the deceased alive on July 3, 1949, and that death occurred at 6:00 P.M., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Shaw, M. D.	1 E. Lexington St.	7/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-6-49	New Cathedral	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 5 1949	Huntington Williams, M.D.	Leonard J. Luck	5305 Harford

VS 150

937

G75969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33

G75969

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) ANNA CAROLINE BAIER

2. DATE OF DEATH July 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2117 Dennison St.

C. Length of stay in Baltimore — Yrs. Life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20 ward
D. STREET ADDRESS (If rural, give location) 314 Stinson St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Widow	Jan. 22, 1892	57	5 / 12	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Maryland	U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	None	None	Charles A. Baier	609 Dennison St.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Thrombosis of st femoral artery — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Coronal Thrombosis — 3 wks

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 1, 1949 *to* July 4, 1949 *that I last saw the deceased alive on* 7/4, 1949 *and that death occurred at* 11 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Weller M.D. M.D.	203 S. Wilkens ave	7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-7-49	Loudon Park	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Huntington Williams, M.D.	Geo. L. Schwab	2101 Frederick Ave.

A-S 150

8 3 B

Please write the cause of death clearly and legibly. Physician's signature is especially important.

G75970 ✓ G75970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): FANNIE MAY Baker

2. DATE OF DEATH: July 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3211 MAGNOLIA Ave

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-42
D. STREET ADDRESS (If rural, give location): 3211 MAGNOLIA Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	MARRIED	Aug 24, 1876	72 73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE		

13. FATHER'S NAME: John Edwards

14. MOTHER'S MAIDEN NAME: LAURA BURKE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT: HOWARD B Baker — ADDRESS: 3211 MAGNOLIA

MEDICAL CERTIFICATION

(Physician: please write the cause of death clearly and correct age is especially important.)

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 20 years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* December, 1945 *to* July, 1949 *that I last saw the deceased alive on* July 1, 1949 *and that death occurred at* 9:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Morris W. Steinberg M. D.	410 N. Milton St	July 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
BURIAL	7/7/49	MT. OLIVET CEM.	BALTIMORE, MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Huntington Mathiews, M.D.	John F. Denny Inc	715 Light

VS 150

61

G75971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 600.0

Registered No. G75971

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mr. Charles William Elder

2. DATE OF DEATH July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore 55y

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2816 Maisel Street 25-43

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower | 8. DATE OF BIRTH Aug 31 1880 | 9. AGE (In years last birthday) 68 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Balto. Transit Pensioner

10B. KIND OF BUSINESS OR INDUSTRY Street Railway

11. BIRTHPLACE (State or foreign country) Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-10-0408

17. INFORMANT Charles F. Barton ADDRESS 2816 Maisel St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO Hypertension

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/24/ , 1949 *to* 7/5/ , 1949, *that I last saw the deceased alive on* 7/5/ , 1949, *and that death occurred at* 1:35 PM, *from the causes and on the date stated above.*

23A. SIGNATURE Thaddeus Dworniski M. D. | 23B. ADDRESS 1400 N. Caroline Street | 23C. DATE SIGNED 7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7/8/49 | 24C. NAME OF CEMETERY OR CREMATORY London Park | 24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 6 1949 VS 150 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR William Cook Sons | ADDRESS 1217-19 Park Ave

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

133a

G75972 CERTIFICATE CORRECTED 7-14-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57° 5

G75972 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SANTO CATALANO

2. DATE OF DEATH 7-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1516 Edmondson Avenue 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Oct 7 1893	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor	Clothing	Italy	

13. FATHER'S NAME Salvatore Catalano 213-10-8688

14. MOTHER'S MAIDEN NAME Anna (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, under unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N	—	220-14-1610	Mrs Anna Salemi	2211 E Preston St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HEPATO RENAL DISEASE
DUE TO
(B) COLOSTOMY (SURGICAL) for
DUE TO
(C) INTESTINAL OBSTRUCTION

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-24-49	INTESTINAL OBSTRUCTION AT SIGMOID	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-1, 1949 *to* 7-5, 1949, *that I last saw the deceased alive on* 7-5, 1949, *and that death occurred at* 12:20 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Arnold H. Michael M. D.	SINAI HOSPITAL BALTO MD	7-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/7/49	Holy Cross	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Huntington Williams, MD	Wilmot & Son	2170 Pine St

VS 150

1226

Please write the cause of death clearly and legibly. Physician: please write the exact age in especially important.

G75973

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13-1

G75973

Registered No.

1. NAME OF DECEASED (Type or Print) Gertrude W Jacobson

2. DATE OF DEATH July 5,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Nel Mar Apts

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Nel Mar Apts. Apt A 2 Brookfield & Whitelock Sts.

c. Length of stay in Baltimore 62 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-1
D. STREET ADDRESS (If rural, give location) NelMar Apts Brookfield & WhitelockSt

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 1872

9. AGE (In years last birthday) 77 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House "ife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Barish Weinkrantz

14. MOTHER'S MAIDEN NAME Sheva Rosenfeld

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ?

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT William D Jacobson ADDRESS Nel Mar Apts Brookfield Av Whitelock St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 6th, 1949 *to* July 4, 1949 *that I last saw the deceased alive on* July 4 1949 *and that death occurred at* 6:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Ernest L Edlow M. D.

23B. ADDRESS 2353 Eutaw Pl.

23C. DATE SIGNED 7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 6,1949

24C. NAME OF CEMETERY OR CREMATORY Hebrew Friendship Cem

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 6 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR Sol Levinson & Bros

ADDRESS 1126 W North Ave

VS 150

46 B

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G75974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75974

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bochnowicz, Doris Lee

2. DATE OF DEATH: July 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 508 S. Wolf 203

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
F.	W.	Married	June 10-1930	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Wife.		Balto.	

13. FATHER'S NAME: Karl Miller

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: John Bochnowicz ADDRESS: 508 S. Wolf St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Lymphatic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 17, , 1949 *to* July 4, , 1949 *that I last saw the deceased alive on* July 4, , 1949, *and that death occurred at* 9:25a *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank J. Geraghty M. D.	1400 N. Caroline St	July 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 7/49	Holy Rosary	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6, 1949	Curtis for Williams, M.D.	Fred W. Ozanczuk	74a 1960 Eastern Ave

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

334

G75975

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Catherine Murawski

2. DATE OF DEATH 7-4-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Seton Institute

c. Length of stay in Baltimore 40yrs.+ Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 5116 Cordelia Ave. 22-18

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	white	widow		55				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Tangowski

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT The Seton Institute — ADDRESS 6420 Belstenstown Balto. 15, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiovascular Collapse, following 5 years epileptic state. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Degenerative atrophy of cerebral cortex

DUE TO

(C) Cerebral vascular arteriosclerosis

Syphilis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 25, 1944 *to* July 2, 1949 *that I last saw the deceased alive on* July 22, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE Walter O. Salvers M. D.

23B. ADDRESS Seton Inst. Balto Md

23C. DATE SIGNED 7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 8/49

24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus

24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR JUL 6 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Fred W. Ozmaconis

ADDRESS 85 1930 Eastern Ave

VS 150

Address

G75976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

G75976

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth ~~Pokrywka~~ Pokrywka

2. DATE OF DEATH 7-4-49

3. PLACE OF DEATH
A. Baltimore City Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) City Hospital
C. Length of stay in Baltimore 30 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 6727 Youngstown Ave 21.06.

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M.
8. DATE OF BIRTH June 11-1903
9. AGE (In years last birthday) 46 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electric Plating
10B. KIND OF BUSINESS OR INDUSTRY Rheem
11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joseph Derengowski
14. MOTHER'S MAIDEN NAME Zophia Mayer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-01-2739
17. INFORMANT Joseph Pokrywka ADDRESS 6727 Youngstown Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH 25 Years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Robert B. McFadden M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED 7-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-9-49
24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary
24D. LOCATION (City, town, or county) (State) Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR JUL 1949
REGISTRAR'S SIGNATURE Wallace Williams, M.D.
25. FUNERAL DIRECTOR Wm. B. Fialkowski ADDRESS 2007 Eastern Ave

VS 151

93D

G75977

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

31 G75977
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alexander KOLAKOWSKI (emw)

2. DATE OF DEATH July 4, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 828 S. Bond St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W			65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral hemorrhage.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-7-49	St. Stanislaus	Dundalk av

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Wm. S. Fialkowski 2007 Eastern av

VS 151

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If any item is unknown, write "unknown." Physician: please write the cause of death clearly and legibly. Be exact as to cause of death; omit terms of doubtful significance; and state duration of each disease mentioned. Correct age is especially important.

0759?8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

193 0759?8

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) William L. All

2. DATE OF DEATH July 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3915 N. Charles St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) none

C. Length of stay in Baltimore 20 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY none

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 3915 N. Charles St. 12-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	August 12, 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
attorney	law	Allendale, S. C.	U.S.

13. FATHER'S NAME Angus All

14. MOTHER'S MAIDEN NAME Ida Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
yes	W.W. 1	

17. INFORMANT ADDRESS Mrs. Mary Preston All, 3915 N. Charles St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cerebral Neoplasm

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	no operation	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	no	no

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
no m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	no

22. *I hereby certify that I attended the deceased from* Aug, 1941, *to* July 4, 1949 *that I last saw the deceased alive on* 4 July, 1949, *and that death occurred at* 4P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D. J. Corbin Street	712 Park Ave.	5 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/6/49	Greenmount.	Balt Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Huntington Williams, M.D.	John O. Mitchell & Sons, Inc.	1900 Eutaw Pl.

VS 150

Mahlon B. Mitchell

54B

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75979

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 Registered No. G75979

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Minnie Cromwell Anderson

2. DATE OF DEATH: July 4, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Ambassador Apts.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

c. Length of stay in Baltimore: 81 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Ambassador Apts. 12-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	July 7, 1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Giles Cromwell

14. MOTHER'S MAIDEN NAME: Amanda Harmon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Alma A. Bacon ADDRESS: Ambassador Apts.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio - vascular — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Hypertensive disease — 8 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1940 30 19__, *to* July 4, 1949 *that I last saw the deceased alive on* July 4, 1949 *and that death occurred at* 10 30 *pm., from the causes and on the date stated above.*

23A. SIGNATURE: Homer U. Todd M. D.

23B. ADDRESS: 2108 St. Paul St.

23C. DATE SIGNED: 7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 7/7/49

24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park

24D. LOCATION (City, town, or county) (State): Woodlawn, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Pl.

Walton H. Mitchell

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Dr. Homer U. Todd

BIRTH NO. 75980

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75980

1. NAME OF DECEASED (Type or Print): Henry B. Koch

2. DATE OF DEATH: July 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 110 W. University Pky.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none
c. Length of stay in Baltimore: 65 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 110 W. University Parkway 12-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	divorced	April 11, 1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Koch
14. MOTHER'S MAIDEN NAME: Catherine C. Stalford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Frank Chubb, Jr. ADDRESS: 1122 Belmore Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Malnutrition

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____ 19__ and that death occurred at _____ m., from the causes and on the date stated above.*

23A. SIGNATURE: William G. Hoffrich M. D.
23B. ADDRESS: 5006 Roland Ave.
23C. DATE SIGNED: 7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 7/6/49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Place

VS 150

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PLEASE WRITE PLAINLY, with unfading ink. Use typewriter if possible. Do not use pencil. Be sure to write the cause of death clearly and correct age is especially important. Physician: please write legibly.

A71291 J490

G75981

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75981 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Wanda Patricia Nelson

2. DATE OF DEATH: JUL 5 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 209 High St. - 3-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	single	March 16, 1949		3			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
nobe		Ft. Wayne, Ind.	

13. FATHER'S NAME: David Nelson

14. MOTHER'S MAIDEN NAME: Gladys Mehlretter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
-		-

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Hyperpyrexia - Cause ?	24 hrs.
DUE TO	with peripheral vasc. collapse	24 hrs
(B)	+	
DUE TO	heart failure	4 hrs
(C)		

AUTOPSY

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION: Diffuse myocarditis. (Fiedler's type) pulmonary RU RM RLL

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-4-05, 1949 *to* 7-4-, 1949, *that I last saw the deceased alive on* 7-4-, 1949, *and that death occurred at* 1:05 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm H. Zuhlsdorf M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/6/49	Mt. Olivet Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

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75982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 75982

BIRTH NO.

1. NAME OF DECEASED (Type or Print)	CLIFTON M. RASIN
2. DATE OF DEATH	July 4, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	2431 Arunah Ave.
c. Length of stay in Baltimore (Yrs. Mos. Days)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Md.
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	2431 Arunah Ave. 16-05
5. SEX	male
6. COLOR OR RACE	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	married
8. DATE OF BIRTH	Nov. 24, 1880
9. AGE (In years last birthday)	68 yrs.
If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Retired
10B. KIND OF BUSINESS OR INDUSTRY	Farmer
11. BIRTHPLACE (State or foreign country)	Kent County, Md.
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Joseph Rasin
14. MOTHER'S MAIDEN NAME	Sarah Paca
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	no
(If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	no
17. INFORMANT	Mrs. Marie M. Rasin
ADDRESS	2431 Arunah Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Neuro Syphilis	years
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	General Visceral Failure	1 year

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1 1947 *to* July 4, 1949 *that I last saw the deceased alive on* July 4, 1949 *and that death occurred at* 10 30 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Mendelis M. D.	651 N. Bentalou	7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/7/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	[illegible] Baltimore, Md.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

309

G75983

BIRTH NO. 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

18 1

Registered No. G75983

1. NAME OF DECEASED (Type or Print)	MARIA MAGDALENA (LENA) ROSSMARK
2. DATE OF DEATH	July 5, 1949
3. PLACE OF DEATH: A.	Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	2321 Riggs Ave.
c. Length of stay in Baltimore (Yrs. Mos. Days)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Md.
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	2321 Riggs Ave. 1605
5. SEX	female
6. COLOR OR RACE	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	married
8. DATE OF BIRTH	April 17, 1877
9. AGE (In years last birthday) (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)	72 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	housewife
10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)	Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Not Known
14. MOTHER'S MAIDEN NAME	Not Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	no
(If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	no
17. INFORMANT	Mr. William H. Rossmark
ADDRESS	2321 Riggs Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Bladder — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
July, 1948	Carcinoma Fundus of Bladder	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 11, 1946, *to* July 5, 1949, *that I last saw the deceased alive on* July 1, 1949, *and that death occurred at* 1:40 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	Albert Johnston M. D.	23B. ADDRESS: 2302 Edmondson Ave
23C. DATE SIGNED	July 6/1949	
24A. BURIAL, CREMATION, REMOVAL (Specify)	Burial	
24B. DATE	7/8/49	
24C. NAME OF CEMETERY OR CREMATORY	Lorraine Cem.	
24D. LOCATION (City, town, or county) (State)	Woodlawn, Md.	
DATE RECEIVED BY LOCAL REGISTRAR	JUL 6 1949	
REGISTRAR'S SIGNATURE	Huntington Williams, M.D.	
25. FUNERAL DIRECTOR	WM. J. TICKNER & SONS	
ADDRESS	Balto., Md.	

VS 150

52B

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the cause of death clearly and correct age is especially important. Physician: please write the

75984

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57 G75984 Registered No.

1. NAME OF DECEASED (Type or Print) Grace Davey

2. DATE OF DEATH 7/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1503 W. Balto. St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

c. Length of stay in Baltimore About 50 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto. Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1503 W. Balto St 19-03

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH June 1-1870 | 9. AGE (In years last birthday) 79 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY at Home | 11. BIRTHPLACE (State or foreign country) Kent Co Md | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Elisam Miller | 14. MOTHER'S MAIDEN NAME Martha Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mrs. Martha Levengood ADDRESS 1503 W Balto St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Anemia, Secondary — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
(B) Ca. of head of pancreas — 1 yr

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 4, 1949 *to* July 4, 1949 *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 10:15 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE Tonsoldo Coleen M. D. | 23B. ADDRESS 5901 Park Heights Ave | 23C. DATE SIGNED 7/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7/6/49 | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. | 24D. LOCATION (City, town, or county) (State) Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 6 1949 | REGISTRAR'S SIGNATURE Huntington Williams, MD | 25. FUNERAL DIRECTOR Geo. L. Berger Jr ADDRESS 1517 Hollins St

VS 150

469

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G75985

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Yr. No. 1

G75985

Registered No.

1. NAME OF DECEASED (Type or Print): LEON S GOLDBERG

2. DATE OF DEATH: 7-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3523 White Chapel Road

c. Length of stay in Baltimore: Life (Yrs. / Mon. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-11
D. STREET ADDRESS (If rural, give location): 3523 White Chapel Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 40
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles E
14. MOTHER'S MAIDEN NAME: Rose F.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Leona Goldberg ADDRESS:

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if known. Do not abbreviate. Exact age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

DUE TO

(B) Coronary Sclerosis — 3

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1949 *to* July 4, 1949 *that I last saw the deceased alive on* July 4, 1949 *and that death occurred at* 9:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leon S. Goldberg M. D.
23B. ADDRESS: Medical Arts Bldg
23C. DATE SIGNED: July 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-6-49
24C. NAME OF CEMETERY OR CREMATORY: Beth Tfiloh
24D. LOCATION (City, town, or county): Balto (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

94a

G75986

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Reg. 7 G75986
Registered No.

1. NAME OF DECEASED (Type or Print): Mrs Rose Bornstein
2. DATE OF DEATH: 7-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale
C. Length of stay in Baltimore: 29 Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15th
D. STREET ADDRESS (If rural, give location): 3815 Reisterstown Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. If under 1 year: Months / Days. If under 24 hours: Hours / Min.)
Female	White	married		58

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Russia	

13. FATHER'S NAME: Feshel
14. MOTHER'S MAIDEN NAME: Dinah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Jane Bornstein	3815 Reist Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia + Sepsis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO
(B) Fracture of legs — 10 weeks
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus, Hemiplegia, Arteriosclerosis — Few years

CERTIFICATION APPROVED BY
Earl Boyer M.D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Nursing Home	Levindale Home Baltimore + Green Spring Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
4-3-49 ? P.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Fell out of bed

22. *I hereby certify that I attended the deceased from* 8-17 1945 *to* 7-5, 1949 *that I last saw the deceased alive on* 7-5, 1949 *and that death occurred at* 1 30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Nagel M.D.	Levindale Home	7-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-6-49	Hebrew Mt Carmel	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

186a

G75987 CERTIFICATE CORRECTED 2-8-49 ✓ G75987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) HARRY ~~[illegible]~~ Balch

2. DATE OF DEATH 7-5-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2422 W. Lexington St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2422 W Lexington St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 30 07

c. Length of stay in Baltimore 30 Yrs. ~~Mos. Days~~

D. STREET ADDRESS (If rural, give location) 2422 W Lex St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Single		65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Upholstering	Russia	

13. FATHER'S NAME Benjamin

14. MOTHER'S MAIDEN NAME Hannah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			J D Balachow	1002 Tower Bldg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Coronary Thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: - 2

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/14, 1949, to 7/5, 1949 *that I last saw the deceased alive on* 7/5, 1949, *and that death occurred at* 6 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert J Shochat M. D.	2302 Edmondson Ave	7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-8-49	United Hebrew	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

47D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

G75988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-20-1

G75988

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) HARRY PONITZ

2. DATE OF DEATH 7-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) TEMPLE GARDEN APTS

C. Length of stay in Baltimore LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO 12-1
D. STREET ADDRESS (If rural, give location) ~~MD.~~ MADISON AVE + CLOVERDALE RD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	WIDOW		78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLOTHING MFG.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) NEW YORK

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME HERBERT

14. MOTHER'S MAIDEN NAME PEARL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
MRS. FRED HOTZNER - TEMPLE GARDEN APTS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Infarct — INTERVAL BETWEEN ONSET AND DEATH: Acute.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio Vascular Renal-Angina - Coronary Sclerosis - 2-3 yrs.

DUE TO

(C) Chronic Congestive Heart Failure 2 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Infected Thrombosed Hemorrhoids 2 months.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Aug. 1st, 1947 to July 5th 1949, that I last saw the deceased alive on July 5, 19 49, and that death occurred at 7:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Wm. Brinkhoff M. D.	Emerson Bldg. Baltimore	July 5th 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-7-49	Holland Friendship	Balto / Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Huntington Williams, M.D.	JACK LEWIS INC -	2100 EUTAW PL

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the cause of death clearly and legibly.

G75989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G75989

1. NAME OF DECEASED (Type or Print) MORRIS BLUEFELD

2. DATE OF DEATH 7-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3313 Royce Ave

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 24 16
D. STREET ADDRESS (If rural, give location) 3313 Royce Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married		35		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Caterer	Food	Balto. Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles	Bessie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Rose Bluefeld	3313 Royce Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: about 24 yrs. to the Knowledge.
DUE TO Aortic stenosis & insuff.
(B) Mitral stenosis & insuff.
DUE TO Cardiac hypertrophy
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 1925, *to* July 6, 1949 *that I last saw the deceased alive on* June 6, 1949 *and that death occurred at* 7a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathan H. Shpritz M.D.	1810 Eutaw Pl.	7/6/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-7-49	Hebrew Young Men	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS-150

92B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

G75990

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75990

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Ada E. Alsia.

2. DATE OF DEATH: July 4 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1513 Union Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1513 Union Ave. 13-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	March 23 1875	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	—	Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Moore	Mary Welsh.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	Thomas Alsia	1513 Union Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Arteriosclerosis

DUE TO

(C) Diabetes Mellitus.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from July 1937 to July 1949, that I last saw the deceased alive on July 4 1949, and that death occurred at 2:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William F. Kelbrick M. D.	5006 Roland Ave	July 5, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 6 1949	Mt Moriah	Hampden.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Huntington Williams, M.D.	Paul E. Shenowith Jr.	3615-17 Chestnut Ave.

VS 150

61

G75991

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1760 Registered No. G75991

1. NAME OF DECEASED (Type or Print): ALICE M. LOHMEYER

2. DATE OF DEATH: July 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Boston Gen Hospital

C. Length of stay in Baltimore: 69 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 31, Md
D. STREET ADDRESS (If rural, give location): 2003 Eastern Ave 2-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married		64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Boos

14. MOTHER'S MAIDEN NAME: Wood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Lohmeyer ADDRESS: 2003 Eastern Ave

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Femur (c) — INTERVAL BETWEEN ONSET AND DEATH: 54 days

DUE TO

(B) Dilation Malleus — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Pulmonary Edema — 1 day

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
William J. McClafferty, M.D.
For: Wm. H. Kammer, Jr. M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2003 Eastern Ave 2/3

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): May 10, 1949 m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21F. HOW DID INJURY OCCUR? Fell fell while getting out of bed

22. *I hereby certify that I attended the deceased from* May 10, 1949 *to* July 3, 1949, *that I last saw the deceased alive on* July 3, 1949, *and that death occurred at* 4P m., *from the causes and on the date stated above.*

23A. SIGNATURE: John M. Bleyer Jr M. D.

23B. ADDRESS: South Boston Gen Hosp

23C. DATE SIGNED: July 3, 49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: JULY 6. 49

24C. NAME OF CEMETERY OR CREMATORY: Parkwood

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949

REGISTRAR'S SIGNATURE: Huntington for Williams, M.D.

25. FUNERAL DIRECTOR: L. HECHMANN & SON ADDRESS: 6067 Harford Rd

VS 150

186a

G75992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#976

Registered No. G75992

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD B. SNYDER N-803.7

2. DATE OF DEATH July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital
C. Length of stay in Baltimore — Yrs. life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glenarm, Md.
D. STREET ADDRESS (If rural, give location) Mt. Vista & Stoney Batter Rds.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widower	Sept. 9, 1897	51				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman	Baltimore Co.	Baltimore Co., Md.	USA

13. FATHER'S NAME: Issac Snyder

14. MOTHER'S MAIDEN NAME: Elizabeth Prigel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT — ADDRESS: Mr. Ray Snyder Mt. Vista Rd., Glenarm R.D.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of head

DUE TO Fracture, skull

(B) Laceration, brain

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	HOME	Glenarm, Maryland

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21F. HOW DID INJURY Ooccur?
July 2, 1949 ? m.		Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
William J. McClafferty M.D.	[X]	July 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/8/49	St. Michaels Lutheran	Perry Hall, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JUL 6 1949	Huntington Williams, M.D.	Lassahn Funeral Home 7401 Belair Rd.

VS-151

164c

G75993

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

9-918.8 G75993

Registered No.

1. NAME OF DECEASED (Type or Print): James G. Duffy — N-921.4

2. DATE OF DEATH: July 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2332 Aiken Street

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2332 Aiken Street — 9-08

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: June 10, 1925
9. AGE (In years last birthday): 24
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William J. Duffy

14. MOTHER'S MAIDEN NAME: Winefred J. Flaherty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — ADDRESS: Wm. J. Duffy, 2332 Aiken Street

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Pulmonary edema — 5 days

DUE TO Severe burns + shock + pulmonary infarct

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? none

22. *I hereby certify that I attended the deceased from* July 2, 1949 *to* July 3, 1949 *that I last saw the deceased alive on* July 3, 1949, *and that death occurred at* 3:05 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 101 N Linwood Ave
23C. DATE SIGNED: July 5 '49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-6-49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949
REGISTRAR'S SIGNATURE: [signature] Baltimore, Md.

25. FUNERAL DIRECTOR — ADDRESS: Leonard J. Ruck, 5305 Harford Road.

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G75994

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75994

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print)	ELLA JONES	2. DATE OF DEATH	July 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
c. Length of stay in Baltimore: 50 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 12 N. Durham Street 6-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	Colored	Married	Nov. 7 78	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unkown	Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Peter E. Jones	13 N. Durham St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic cardiovascular	
	DUE TO disease	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George L. Merrill M.D.		7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-6-49	Mt Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Huntington Williams, M.D.	Elroy O. Wilson	1000 Brantly Ave.

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75995

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75995

1. NAME OF DECEASED (Type or Print): Harry Francis

2. DATE OF DEATH: 7/1/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1208 E. Lexington St.

C. Length of stay in Baltimore: 60 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1208 E. Lelington St 5-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If less than 1 year, months; if less than 24 hours, hours)
Male	Col.	Widower	12/14/1869	79 (Years / Months / Days / Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumber Inspector

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington Dc.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unkown

14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Williemay Dickerson ADDRESS: 1208 E. Lex. ST.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Accuracy is especially important. Physician please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hydronephrosis Left Kidney
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Generalize Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 1949 *to* June 30, 1949 *that I last saw the deceased alive on* 7-1, 1949, *and that death occurred at* 10:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 1113 N Caroline St

23C. DATE SIGNED: 7-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 7/6/1949

24C. NAME OF CEMETERY OR CREMATORY: Mt Calvery Cem.

24D. LOCATION (City, town, or county) (State): Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Elroy O. Wilson 1000 Brantly Ave.

VS 150

52a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G75996 — Registered No. G75996

1. NAME OF DECEASED (Type or Print): Elizabeth A. Murphy
2. DATE OF DEATH: 7-6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 854 Harford Ct.
C. Length of stay in Baltimore: 72 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 854 Harford Ct.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	March 16 1877	72	3	26

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waitress, Restaurant	Penn. R.R.	Baltimore Md.	U.S.A.

13. FATHER'S NAME: Fabrick J. Murphy
14. MOTHER'S MAIDEN NAME: Margaret N. Cullan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Miss Margaret N. Murphy	854 Harford Ct.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Heart Prostatic
DUE TO
(B) Severe anemia — Malnutrition
DUE TO
(C) Hypokusion.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. , 1948 *to* June 24, 1949 *that I last saw the deceased alive on* June 24, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mabrs A Brie M. D.	11E Biddle St	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-8-49	New Cathedral Cemetery	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Huntington Williams, M.D.	Edward W. Conklin	924 E. Eager St

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physician please write the cause of death clearly and legibly.

VS 150

73D

G75997

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G75997 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George H. Revere

2. DATE OF DEATH JUL 4 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 41 Yrs. Mos. Days.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-06
D. STREET ADDRESS (If rural, give location) 3043 Harlem Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	11-15-82	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Va
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME George W. Revere
14. MOTHER'S MAIDEN NAME Virginia ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, as correct age is especially important. Physician please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of esophagus — INTERVAL BETWEEN ONSET AND DEATH ±6 mo
DUE TO
(B) —
DUE TO
(C) heart failure - post op hemorrhage

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. failure line disruption

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
(1) 6/13/49 (2) 7/2/49	(1) Ca of Esophagus (2) ? erosion of aorta	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE? (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-10-1949 *to* 7-4-1949, *that I last saw the deceased alive on* 7-4-1949, *and that death occurred at* 6:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Irvine E. Chaney Jr. M. D.	JOHNS HOPKINS HOSPITAL	7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	JULY 7 '49	LOUDON PARK	BALTO. MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Torrington Williams, M.D.	Harry A Tyler	401 Edmondson Ave

VS 150

46a

BIRTH NO. G75998

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G75998

1. NAME OF DECEASED (Type or Print): KATHERINE M MUELLER

2. DATE OF DEATH: JULY 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): GERMAN AGED PEOPLES HOME
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 22 S. ATHOL AVE 21 04.

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: NOV. 30 1873
9. AGE (In years last birthday): 75
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOHN G MUELLER
14. MOTHER'S MAIDEN NAME: KATHERINE WENTZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. J. GEO. HALL - 22 S. ATHOL AVE ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Intestinal Intoxication — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO
(B)
DUE TO
(C) Possible fatty cardiac degeneration.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH; BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypo-thyroidal.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1/49, 19__, *to* July 4/49, 19__, *that I last saw the deceased alive on* July 3, 1949, *and that death occurred at* 1.55 P.M. *on the causes and on the date stated above.*

23A. SIGNATURE: Henry Wade Chaney M. D.
23B. ADDRESS: 933 Hanover St. Balto. 30, Md.
23C. DATE SIGNED: July 5

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: JULY 6 '49
24C. NAME OF CEMETERY OR CREMATORY: BALTIMORE
24D. LOCATION (City, town, or county) (State): BALTO. MD

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949
REGISTRAR'S SIGNATURE: Tuthington Williams, M.D.
25. FUNERAL DIRECTOR: Harry A Wolfe ADDRESS: 4101 Edmondson Ave

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Data as to the cause of death clearly and legibly. Physician please write the correct age is especially important.

G75999

BIRTH NO. B.C.49-04972 G75999

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

491 Registered No.

1. NAME OF DECEASED (Type or Print): David Riley

2. DATE OF DEATH: 7/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1632 E. Pratt St. 3-11

5. SEX: Male.
6. COLOR OR RACE: White.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Infant
8. DATE OF BIRTH: 3/4/49
9. AGE (In years last birthday): If Under 1 Year: Months 3 Days 29; If Under 24 Hours: Hours 4 Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David Riley
14. MOTHER'S MAIDEN NAME: Anna. Pellegrini

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: 1632 E. Pratt St. ADDRESS Anna. Pellegrini

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Parenteral diarrhoea & severe acidosis

DUE TO

(B) Bronchopneumonia

DUE TO

(C) CPC

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/3/49, 19__, *to* 7/3/49, 19__, *that I last saw the deceased alive on* 7/3/49, 19__, *and that death occurred at* 7.20P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lee N Kastner M. D.
23B. ADDRESS: Sinai Hosp.
23C. DATE SIGNED: 7/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 6. 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer.
24D. LOCATION (City, town, or county) (State): Belair Road Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949
REGISTRAR'S SIGNATURE: Hunter Town Williams, M.D.
25. FUNERAL DIRECTOR: Arendell Skipper
ADDRESS: 3112 Virginia Ave

VS 150

119a

To be certified by Med Examiner ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76000

BIRTH NO. G76000

163

1. NAME OF DECEASED (Type or Print): Johnson, Frank

2. DATE OF DEATH: 7/5/99

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1519 Division St (If not in hospital or institution, give street address or location)

B. FULL NAME OF HOSPITAL OR INSTITUTION: Provident Hospital

c. Length of stay in Baltimore: 9 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE [redacted]
B. COUNTY Maryland
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) 12 - O
D. STREET ADDRESS (If rural, give location) 26 W. Lafayette Ave

5. SEX: Male | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 6/15/99 | 9. AGE (In years last birthday): 56 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Cottagetown, Va

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Hemorrhage

DUE TO

(B) Carcinoma of Lung right

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Dehydration - Anemia

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
G. H. Merrill
For: Robert McFadden M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION: Feb 1949

19B. MAJOR FINDINGS OF OPERATION: Inoperable Carcinoma right lung

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Febz 1999 *to* 7/5 1999, *that I last saw the deceased alive on* 7/5 1999 *and that death occurred at* 6 05 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Dr Marcus W. Moore M. D.

23B. ADDRESS: Provident Hospital

23C. DATE SIGNED: 7/6/99

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 9

24C. NAME OF CEMETERY OR CREMATORY: Lexington, Va.

24D. LOCATION (City, town, or county) (State): Lexington, Va.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR AND ADDRESS: Geo. W. Kelson 1303 Pennsylvania Ave

VS 150

475

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Accuracy is important. Physician: please write the cause of death clearly and legibly.

G76001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 G76001

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM ROYSTER

2. DATE OF DEATH July 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore 45 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 614 Sarahanne Street 4-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	Colored	Widowed	I868	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Clarksville, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Lillian Elliott 6I4 Sarahann St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypertensive arteriosclerotic cardio-vascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7-7-49	MT. CALVARY	A.A. Co. MD

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE Washington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Wm. A. Jackson. 916 Penn Ave.

JUL 6 1949

93D

BIRTH NO. G76002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76002

1. NAME OF DECEASED (Type or Print): WILLIAM THOMAS

2. DATE OF DEATH: July 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland I823 Rayner Ave,.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore 38 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) I823 Rayner Ave,. 16 04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	Colored	Married	August I895	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Virginia	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jerry Thomas ,	Nancy Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mrs. Helen Thomas,	I823 Rayner Ave,.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Erase the cause of death clearly and legibly. Correct age is especially important. Physician: please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY THROMBOSIS (EMBOLISM) — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) CONGESTIVE HT. FAILURE — 5 MONTHS
(C) AND THROMBD PHLEBITIS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 18, 1949, *to* July 4, 1949, *that I last saw the deceased alive on* July 2, 1949, *and that death occurred at* 11:10 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William L. Washington Jr. M. D.	1535 W. Lexington St	July 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-10-49	Arbutus Memoral Pk.	Baltimore Co, Md,.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Huntington Williams, M.D.	Wm. A. JACKSON	916 PENNA. AVE

VS-150

94a

G76003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

G76003

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Mirko Woynovitz | 2. DATE OF DEATH: 7/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1300 Kuper St
c. Length of stay in Baltimore: 47 Yrs. 4 Mos. 5 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1300 Kuper St 19-03

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: 2/22/1879 | 9. AGE (In years last birthday): 70 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist Helper | 10B. KIND OF BUSINESS OR INDUSTRY: Bolto Transit | 11. BIRTHPLACE (State or foreign country): Hungary | 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Woynovitz | 14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown): No | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service): 213-10-0715 | 17. INFORMANT: Anna Woynovitz | ADDRESS: 130 Kuper St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive C. V. disease. — INTERVAL BETWEEN ONSET AND DEATH: 10 years.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 2, 1949 *to* July 5, 1949 *that I last saw the deceased alive on* July 5, 1949, *and that death occurred at* 2:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Julian Lebherz M. D. | 23B. ADDRESS: 3429 Liberty Heights Ave. | 23C. DATE SIGNED: July 6, 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 7/8/49 | 24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem. | 24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949 | REGISTRAR'S SIGNATURE: Thomas Williams M.D. | 25. FUNERAL DIRECTOR: Roll & B. M. Walter | ADDRESS: Pratt & Hanlon

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to state the cause of death clearly and fully. Give correct age if especially important. Physician: please write the

G76004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76004

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): FRANK A. LAKE

2. DATE OF DEATH: July 4- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1704 W. Fayette St
c. Length of stay in Baltimore: 3 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1704 W. Fayette St. 19 02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	6/25/1897	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Weaver	Textile Mills	Zepp Virginia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charlie V. Lake	Ellen Shell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes WW I and 2	227-09-5159	Ella Funkhouser	179 Fulton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO

(B) Arteio sclerotic cardio-vascular disease — 5 years.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 3, 1949, *to* July 4, 1949, *that I last saw the deceased alive on* July 3, 1949, *and that death occurred at* 9:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert E. Faber M. D.	Sparrows Point, Md	July 5, 1949

24A. BURIAL, CREMATION OR REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 7 1949	Baltimore National	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR
JUL 6 1949	Huntington Williams M.D.	Pott & B. McWaeton Pott & Stickney Inc

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Erase the cause ● of death clearly and correct age is especia● important. Physicia●: please write the cause ● of death clearly and legibly.

93D

G76005 ✓X G76005

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 173

Registered No.

1. NAME OF DECEASED (Type or Print): Mary Bolling

2. DATE OF DEATH: July 4, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: 20 (Yrs, Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Merrittsville, Md.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widowed	Oct. 12, 1882	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maid	Domestic	Virginia	U. S.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Nancy Massie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: William Swailes ADDRESS 694 Lorch Court

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in the cause of death clearly and correct age is especially important. Physicians: please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Uterus — INTERVAL BETWEEN ONSET AND DEATH: 6 Months
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 1949 *to* July 4, 1949 *that I last saw the deceased alive on* July 4, 1949, *and that death occurred at* 10:10 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mary E. Matthews M. D.		6/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/6/49	Arbutus Memorial	Arbutus Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR: Mrs Katie R. Williams ADDRESS 3227 Sch...

VS 150

48B

G76006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

493 Registered No. G76006

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sallie Campbell

2. DATE OF DEATH: July 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 919 W. Franklin

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 919 W. Franklin St

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
919 W. Franklin St.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18 01
D. STREET ADDRESS (If rural, give location): 919 W. Franklin St.

5. SEX: Female
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: April 21, 1881
9. AGE (In years last birthday): 68 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Salisbury, S.C.
12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME: William Fisher.
14. MOTHER'S MAIDEN NAME: Julia Lord.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. K. R. Williams ADDRESS: 322 N. Schroeder

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, with unfading ink. Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia
DUE TO
(B) Congestive failure
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 29, 1949, *to* July 2, 1949 *that I last saw the deceased alive on* July 1, 1949, *and that death occurred at* 1:10 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Romus V. Benjamin M. D.
23B. ADDRESS: 1834 Edmondson Ave
23C. DATE SIGNED: 7/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/6/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 vs 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams
ADDRESS: 322 N Schroeder St

109B

G76007 ✓ G76007

G76007

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WAITES, THOMAS

2. DATE OF DEATH 7-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSP.
c. Length of stay in Baltimore 20 Yrs. Mos. Days.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 119 N. Mount St. 19-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	B	M	Jan. 1, 1909	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U-S.
13. FATHER'S NAME Emanuel Waites
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT WIFE (DELORES) ADDRESS 119 N. Mount St

MEDICAL CERTIFICATION

PLEASE WRITE LEGIBLY, WITH INK. Immediately after death, please write the cause of death clearly and legibly. Do not state mode of dying, such as heart failure, asthenia, etc., but the disease causing death. Also correct age if especially important. Physician please sign.

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARDIAC DECOMPENSATION
DUE TO
(B) HYPERTENSIVE CARDIOVASCULAR

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO DISEASE
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-2, 1949 *to* 7-3, 1949 *that I last saw the deceased alive on* 7-3, 1949, *and that death occurred at* 6:00 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Wm Blamp M. D.
23B. ADDRESS Franklin Sq. Hosp.
23C. DATE SIGNED 7-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/6/49
24C. NAME OF CEMETERY OR CREMATORY Mt Zion Cem
24D. LOCATION (City, town, or county) (State) Lansdowne Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 6 1949
REGISTRAR'S SIGNATURE Functioning for Williams, M.D.

25. FUNERAL DIRECTOR Mrs Katie R. Williams
ADDRESS 3221 Schroeder St

937

G76008 ✓ G76008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 173 Registered No.

1. NAME OF DECEASED (Type or Print) Katie W. Frock

2. DATE OF DEATH July 4 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2711 W. Belvedere Ave.

c. Length of stay in Baltimore Yrs. Mos. Days 22-11

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md COUNTY Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2711 W. Belvedere Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	April 14 1887	62 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Saleslady	Department Store	Balto Co. Md	U.S.A.

13. FATHER'S NAME Samuel S. Frock

14. MOTHER'S MAIDEN NAME Olive E. Wenzel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	218-10-6940	Miss Mary A. Frock	2711 W. Belvedere Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Angina Pectoris — INTERVAL BETWEEN ONSET AND DEATH: July 4/49

DUE TO

(B) Cancer of uterus — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 15, 1949, *to* July 4, 1949, *that I last saw the deceased alive on* July 4, 1949, *and that death occurred at* 10:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hen D Bubert M. D.	4803 Park Heights Ave	7-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-7-49	London Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
	[illegible] Williamson	Loring Byers	5005 Pk Heights Ave.

PLEASE WRITE LEGIBLY. Indicate the cause of death clearly and correct age is especially important. Physician please write the

VS 150

JUL 6 1949

48B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76009 — 760-5 — Registered No. G76009

1. NAME OF DECEASED (Type or Print): Barney Bray Welch

2. DATE OF DEATH: July 5, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): John Hopkins
C. Length of stay in Baltimore: Yrs. Mos. Days — 1 day

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: St. Marys
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chaptico Mechanicsville 12 F.
D. STREET ADDRESS (If rural, give location)

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 7/6/19
9. AGE (In years last birthday): 29 F. B. — If Under 1 Year: Months — Days: 1 — If Under 24 Hours: Hours — Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Dr. Cornelius H Welch
14. MOTHER'S MAIDEN NAME: Christine Middleton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Dr. Cornelius Welch

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH:
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intracranial hemorrhage
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-5 1949 *to* 7-5 1949 *that I last saw the deceased alive on* 7-5 1949 *and that death occurred at* 3 16 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: W. D. Young, M. D.
23B. ADDRESS
23C. DATE SIGNED: 7-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-7-49
24C. NAME OF CEMETERY OR CREMATORY: St. Joseph's
24D. LOCATION (City, town, or county) (State): Morganza, Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: P. B. Robinson, Leonardtown, Md.

160a

PLEASE WRITE PLAINLY. Please write the cause of death clearly and correct age is especially important. Physician please write the

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76010 — Registered No. G76010

1. NAME OF DECEASED (Type or Print): MATILDA BEDFORD

2. DATE OF DEATH: July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-1
D. STREET ADDRESS (If rural, give location): 1033 N. Central Avenue

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH
9. AGE (In years last birthday): 73 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Dorchester County Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles Cole
14. MOTHER'S MAIDEN NAME: Harriett ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

16. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ — NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George A. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/8/49
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Pk
24D. LOCATION (City, town, or county) (State): Arbutus, Md
DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949
REGISTERED BY: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: Joseph B. Locke Jr. — ADDRESS: 1304 N. Carey

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VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Write the cause of death clearly and legibly. Give correct age in especially important. Physicians: please write the cause of death clearly and legibly.

G76011 BALTIMORE CITY HEALTH DEPARTMENT G76011

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): CLYDE WILLIAM BAUMGARDNER

2. DATE OF DEATH: July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital
Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: 16 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Biglersville
D. STREET ADDRESS (If rural, give location): Route 1

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 4/3/04
9. AGE (In years last birthday): 45 (If under 1 year: Months, Days; If under 1 day: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steward
10B. KIND OF BUSINESS OR INDUSTRY: Seafarer

11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Oscar Baumgardner

14. MOTHER'S MAIDEN NAME: Florence Rhodes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: 276-05-7619

17. INFORMANT: Records- US Marine Hospital, Balto, Md. ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, with ink or indelible pencil. Do not use abbreviations or ditto marks. Be sure to write the cause of death clearly and correct age is especially important. Physician: please write legibly.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rupture of esophageal varix — Interval between onset and death: 1 day
DUE TO
with hemorrhage, due to
(B) Portal cirrhosis — 1 yr.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 20, 1949 *to* July 6, 1949, *that I last saw the deceased alive on* July 6, 1949, *and that death occurred at* 8:10 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson M. D.
23B. ADDRESS: US Marine Hospital, Balto, Md.
23C. DATE SIGNED: 7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 9 1949
24C. NAME OF CEMETERY OR CREMATORY: Biglerville
24D. LOCATION (City, town, or county) (State): Biglerville, Adams Co., Pa.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE:

25. FUNERAL DIRECTOR: M. E. Dugan Bendersville, Pa. ADDRESS

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(E. Howard)

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G76012 ✓ ✓ G76012

BIRTH NO. G76012

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): John B Greene

2. DATE OF DEATH: 7-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital
c. Length of stay in Baltimore: 35 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14
D. STREET ADDRESS (If rural, give location): 2701 Strathmore 27-3

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 3 1893
9. AGE (In years last birthday): 56 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Appraiser
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Greene William E
14. MOTHER'S MAIDEN NAME: Hargrave, Sally E

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Records
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonectomy, Left.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 7 days

19A. DATE OF OPERATION: June 29 1949
19B. MAJOR FINDINGS OF OPERATION: Tuberculosis of Left Lung
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-27 1949 *to* 7-5 1949 *that I last saw the deceased alive on* 7-5 1949 *and that death occurred at* 3:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Lee M. Howard M. D.
23B. ADDRESS: Church Home & Hosp.
23C. DATE SIGNED: 7-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-7-49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck
ADDRESS: 5305 Harford.

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Please write clearly and legibly. Use ink. Do not use pencil. Be sure the cause of death is entered correctly. Physician: please write the cause of death clearly and legibly. Be sure the correct age is especially important. Physician: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76013

Registered No. G76013

1. NAME OF DECEASED (Type or Print) EVERETT R. BERNHARDT

2. DATE OF DEATH July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5605 Birchwood Avenue 27-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	4-19-1895	54		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Canton Lumber
11. BIRTHPLACE (State or foreign country): Balto Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Henry Bernhardt
14. MOTHER'S MAIDEN NAME: Mary E. Dover
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Bertha Bernhardt ADDRESS 5605 Birchwood

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Report only one cause of death clearly and legibly. Do not enter mode of dying, such as heart failure, asthenia, etc. Do not enter terminal disease without the cause of death. Physician: please write the cause of death in the space provided. Exact age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED July 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-8-49	Oaklawn	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 6 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR Leonard J. Leuck ADDRESS 5305 Harford Rd

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G76014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

37 G76014

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) CRAWFORD V. SEVIER

2. DATE OF DEATH 7-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 14
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 27-7
D. STREET ADDRESS (If rural, give location) 2706 NORTHERN PKWY

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	10-22-1904	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tech. Asst. Eng.
10B. KIND OF BUSINESS OR INDUSTRY G-F Co.
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Greenbury M. Sevier
14. MOTHER'S MAIDEN NAME Rose Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Eva Sevier - ADDRESS 2706 Northern Pkwy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Brain Tumor — INTERVAL BETWEEN ONSET AND DEATH 9 yrs.
DUE TO (benign)
ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-5-49	Vascular intracranial neoplasm	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1 July, 1949, *to* 5 July, 1949, *that I last saw the deceased alive on* 5 July, 1949, *and that death occurred at* 3:15 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John W. Stowe M. D.	University Hospital	7-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-9-49	Baltimore	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Washington Williams, M.D.	Leonard J. Luck	5305 Harford

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Please write the cause of death clearly and correct age, if especially important. Physician:

G76015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 3

Registered No. G76015

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNA Theresa BONADIO

2. DATE OF DEATH: July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-10
D. STREET ADDRESS (If rural, give location): 811 Richwood Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Female	White	married	4-1-1912	37		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Frederick, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alexander Heir
14. MOTHER'S MAIDEN NAME: Matilda Mc Cardell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Peter Bonadio — ADDRESS: 811 Richwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary embolus
DUE TO
(B) Phlebitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* _____ (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-9-49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949
25. FUNERAL DIRECTOR: Leonard J. Luck
ADDRESS: 5305 Harford

100B

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Please write the cause of death clearly and legibly. Physician: please write especially important.

G76016 m.s. ✓ G76016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD PHILLIPS

2. DATE OF DEATH July 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General Hospital

c. Length of stay in Baltimore Life. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 24-3
123 East Clement Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Married.	March, 10, 1910	39yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Warehouse clerk.	A. & P. Co.	Baltimore, Md.	U. S.

13. FATHER'S NAME
John A. Phillips.

14. MOTHER'S MAIDEN NAME
Maggie Stump.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
----	----	215-05-2978

17. INFORMANT Albert S. Chambers ADDRESS (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Artery Disease	
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*
Autopsy, Inspection or Inquiry

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
William J. McCafferty M.D.		July 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 8, 1949	Cedar Hill Cem.	A.A. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
7/5/49	Huntington Williams, M.D.	A. HOWARD EVANS	1400 S. Charles St. Baltimore 30, Md.

PLEASE WRITE PLAINLY, with unfading ink. Be sure to report the cause of death clearly and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 151

94a

A. Howard Evans

G76017 BALTIMORE CITY HEALTH DEPARTMENT G76017

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Thomas Woods

2. DATE OF DEATH: July 5 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore City Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: About 45 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Lansdowne
D. STREET ADDRESS (If rural, give location): 2619 Rolling Avenue Lansdowne

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	7-26-1878	70	11	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): B.&O. R.R. Engineer
10B. KIND OF BUSINESS OR INDUSTRY: Retired.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Barney Woods
14. MOTHER'S MAIDEN NAME: Sarah (?)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Thomas J. Woods Jr. ADDRESS: Ave. Lansdowne 15-5th

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congestive Failure
DUE TO
(B) Primary Bronchogenic Carcinoma
DUE TO
(C) —

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 7/1/49
19B. MAJOR FINDINGS OF OPERATION: Hernia Petit Triangle
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 6/29/49 *to* 7/5, 19 49 *that I last saw the deceased alive on* 7/5, 19 49 *and that death occurred at* 5:10 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Frank Bryan M.D.
23B. ADDRESS: St Agnes Hosp
23C. DATE SIGNED: 7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 8-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem Balto Md
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: C. Howard Evans ADDRESS: 1400 S. Charles St Balto 30 Md

VS 150

47c

PLEASE WRITE PLAINLY. Physician: please write the cause of death clearly and legibly. Use only standard abbreviations. Be sure the correct age is especially important.

G76018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76018

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MR. CHARLES U. Hodge SR. — 2. DATE OF DEATH 7/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Bon Secours Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hosp.
c. Length of stay in Baltimore 12 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-7
D. STREET ADDRESS (If rural, give location) 3701 Edmondson Ave #29

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Feb. 3, 1904	45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Agent	Real Estate	Md	U.S.A.

13. FATHER'S NAME Joseph H Hodge — 14. MOTHER'S MAIDEN NAME Annie Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT'S ADDRESS Mrs Chas. Hodge

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diverticulosis of Sigmoid
DUE TO Diverticulitis of semi-colon
c perforation
(B) Peri-sigmoid abscess
DUE TO " " adhesions
(C) Generalized Peritonitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

(over)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/25/49	Inflam. or CA of sigmoid? No malignancy found	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 6/25 19 49, *to* 7/5/49, 19 —, *that I last saw the deceased alive on* 7/5, 19 49, *and that death occurred at* 7:45 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. S. Womack M. D.	Bon Secours Hosp	7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-8-49	Cathedral	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 6 1949	[redacted]	George A. Farley, Fulton and Fayette St.

123

PLEASE WRITE PLAINLY. Physician: please write the cause of death clearly and fully. Correct age is especially important.

G76019

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

17 G76019

Registered No.

1. NAME OF DECEASED (Type or Print): Anna Mildred Talley

2. DATE OF DEATH: July 3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 262 N. Hilton St

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-7
D. STREET ADDRESS (If rural, give location): 262 N. Hilton St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	W.	Married	Oct. 15 1901	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry F. Pellicord

14. MOTHER'S MAIDEN NAME: Annie F. Robey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Wm. Earle Talley, ADDRESS: 262 N. Hilton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma, Right Breast — INTERVAL BETWEEN ONSET AND DEATH: 6 Mos.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 10, 1949, *to* July 2, 1949, *that I last saw the deceased alive on* June 30, 1949, *and that death occurred at* 6:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
DC Mac Laughlin M. D.	4508 Edmondson Village	7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 7/49	Loudon Pk.	3801 Frederick Av. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 6 1949

REGISTRAR'S SIGNATURE: Washington Williams, M.D.

25. FUNERAL DIRECTOR: Harry R. Weitzfelt ADDRESS: 4101 Edmondson Ave.

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Please write plainly; please use ink; important. Physician's signature is especially important.

G76020

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

571.1 G76020

Registered No.

1. NAME OF DECEASED (Type or Print) SAMUEL J. MEADE

2. DATE OF DEATH 7/4/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1517 Presstman St. Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 48yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-1
D. STREET ADDRESS (If rural, give location) 1517 Presstman St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Married	5/10/1869	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Brickyard	Chesterfield Co. Va.	U.S.A.

13. FATHER'S NAME: John Meade

14. MOTHER'S MAIDEN NAME: Martha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	-	-

17. INFORMANT: Julia Meade (W) 1517 Presstman St — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Nephritis Chron

DUE TO

(C) Gastritis Chron

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-3-49 *to* 7-4-1949 *that I last saw the deceased alive on* 7-4-1949 *and that death occurred at* 11:15A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm R Boykin M. D.	1133 N. Monroe	7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/7/49	Providence Baptist Cem.	Carson, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 6 1949	Huntington Williams M.D.	Charles G. Cooper	512 Carrollton Av.

VS 15

Correct age is especially important. Physician please write clearly.

131B

G76021 — BALTIMORE CITY HEALTH DEPARTMENT — G76021

BIRTH NO. — **CERTIFICATE OF DEATH** — Registered No.

1. NAME OF DECEASED (Type or Print): Hester V. Schindler

2. DATE OF DEATH: July 5th 1949 — 2:50 a.m.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 305 E. 27th St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 305 E. 27th St. 12-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Apr. 29th 1903	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Balto. Md.	

13. FATHER'S NAME: J. P. Lyons

14. MOTHER'S MAIDEN NAME: Anna Mabions

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Frank A. Schindler	305 E. 27th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 5-6 mos
DUE TO
(B) Carcinoma of Breast — 2 yr
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1947	Ca Carcinoma of Breast	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/10, 1949 *to* 7/5, 1949, *that I last saw the deceased alive on* 7/4, 1949, *and that death occurred at* 3 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William D. Penner M. D.	16 W. 29th St. Balto	7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/7/49	U. S. National	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	[illegible]	Wm Cook Inc.	1217 St. Paul St.

VS 150

50

D

G76022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76022

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Catherine Ball Felter**

2. DATE OF DEATH **July 6, 1949**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **Baltimore, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **4511 Groveland Avenue**

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** 28-1
D. STREET ADDRESS (If rural, give location) **4511 Groveland Avenue**

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Feb. 29, 1868	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **housewife**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Maryland**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **T. Sewell Ball**

14. MOTHER'S MAIDEN NAME **Esther Haines**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **no**

(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT — ADDRESS **Haines B. Felter, 3707 Hillsdale Road**

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) arteriosclerosis	20
	DUE TO (B) Coronary Thrombosis	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/6, 19 49 *to* 7/6, 19 49 *that I last saw the deceased alive on* 7/6, 19 49, *and that death occurred at* 10, 1 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	3902 Groveland Ave	7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
burial	7/7/49	Druid Ridge Cemetery	Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JUL 7 1949	Huntington Williams, M.D.	Wm. Cook, Inc., 1217 St. Paul Street

VS 150

94a

G76023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76023 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mr. Louis Griesman — 2. DATE OF DEATH July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Pasedena - RURAL
D. STREET ADDRESS (If rural, give location) Mountain Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Widowed	2/2/1866	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Clerk	City of Balto	Baltimore City, Md.	

13. FATHER'S NAME Theodore Griesman
14. MOTHER'S MAIDEN NAME Kunigunda Kroll

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Elizabeth K. Griesman	Pasadena Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral vascular accident
DUE TO
(B) Arteriosclerotic heart disease
DUE TO
(C) Hypertrophied heart, Aortic aneurysms (2) Diverticulosis, colon

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Passive congestion of lungs, liver.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7/4/ , 1949, *to* 7/6/ , 1949, *that I last saw the deceased alive on* 7/6/ , 1949 *and that death occurred at* 12:55 PM, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
O. Andrew Allen, M. D.	1400 N. Caroline Street	7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/9/49	Cedar Hill	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 150

20D

G76024

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

630

Registered No. G76024

BIRTH NO. BC. 47-13253

1. NAME OF DECEASED (Type or Print): Reinhardt, Catherine Pauline

2. DATE OF DEATH: July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's
c. Length of stay in Baltimore: Yrs. Mos. Days: 2 da.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 8-6
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1717 N. Chapel

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
F.	W.	Single	July 4, 1949			2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	Infant	Baltimore	

13. FATHER'S NAME: Joseph Henry Reinhardt

14. MOTHER'S MAIDEN NAME: Pauline Virginia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Joseph Reinhardt ADDRESS: 1717 N. Chapel St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration pneumonia

DUE TO

(B) Aspiration of milk

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
Earl Brey M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
accident	home	1717 N. Chapel Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 6, 1949 8p. m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Aspiration of milk

22. *I hereby certify that I attended the deceased from* July 5, 1949 *to* July 6, 1949, *that I last saw the deceased alive on* July 6, 1949, *and that death occurred at* 8:20a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. Andrew Alecci, M. D.	1400 N. Caroline St.	July 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/8/49	Glen Haven	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Huntington Williams, M.D.	Wm Cook Inc.	217 St. Paul St.

VS. 150

107

G76025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76025

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SOPHIA E. TUSSING

2. DATE OF DEATH July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Mercy Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-4
D. STREET ADDRESS (If rural, give location) 2013 North Calvert Street

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Married	October 14, 1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Balto. Md.	

13. FATHER'S NAME: Gordon Eshet

14. MOTHER'S MAIDEN NAME: Frances Bennett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Mrs Dorothy Benson 38-32 90 Jamaica L.I.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from* (Autopsy, Inspection or Inquiry) *the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
Carl L Royer M.D.		July 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/8/49	Mt. Olivet	Balto - Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 7 1949	Huntington Williams, M.D.	Wm Cook Inc. 1217 St. Paul St.

VS 151

937

PLEASE WRITE the cause of death clearly and legibly. Physician: please write the correct age in years, month, days, hours, minutes if under 1 year. Omit words "about," "probably," etc. Be specific and important.

G76026

JL- 128910

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76026

1. NAME OF DECEASED (Type or Print) **Alfred Belt**

2. DATE OF DEATH **7-5-49**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Baltimore City Hospitals 4940 Eastern Ave.**

C. Length of stay in Baltimore **Life** Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **716 Puritan St- 11** 12-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Wid.	July 18 ? 1873	75 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Fireman	Railroad	Md.	

13. FATHER'S NAME **Alfred (D)**

14. MOTHER'S MAIDEN NAME **Annie Naylor**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT **B. C. H. Records, 4940 Eastern Ave.** ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Arteriosclerotic Heart Disease**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-11-49, 19__, *to* July 5, 19 49 *that I last saw the deceased alive on* July 5, 1949, *and that death occurred at* 9 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. S. Rogers M. D.	4940 Eastern Ave.	

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/8/49	Cedar Hill	U. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Emmington Williams, MD	Wm Cook Inc.	1217 St. Paul St.

VS 150

937

Please write the cause of death correct age is especially important. Physician:

G76027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76027

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BLANCHE AMOS (djm)

2. DATE OF DEATH July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-4
D. STREET ADDRESS (If rural, give location) 324 West Lanvale Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Married	July 31, 1899	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Red Oak, Iowa

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Banjamin F. Smith

14. MOTHER'S MAIDEN NAME Maud Nunn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Sgt. Alan Amos, ADDRESS 3024 W. Lanvale St.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema.

DUE TO

(B) (cause undetermined)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [X].*

23A. SIGNATURE William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED July 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/7/49	Evergreen	Red Oak, Iowa

DATE RECEIVED BY LOCAL REGISTRAR JUL 7 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS William Cook, Inc., 1217 St. Paul St.

VS 151

PLEASE WRITE PLAINLY with pen or pencil, and do not use abbreviations. In stating the cause of death, diseases resulting from the primary cause, or complications, should be clearly described, with the primary cause last. If death was due to external causes, state the accident, suicide or homicide, and describe how injury occurred. Do not report the mode of dying, such as heart failure, asthenia, or shock. Indefinite or unsatisfactory terms, such as "old age," "natural causes," "senility," "debility," etc., should not be used as the principal cause of death. Where practicable, a physician should certify to the cause of death. If not, the coroner is required to investigate the cause of death. Please write the correct age in years, months, days, hours or minutes, as the case may be. Physician: please write the correct age is especially important.

AB-37672

G76028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76028

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Theother Jeffers

2. DATE OF DEATH July 6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 19yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1510 E. Biddle St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	Negro	Married	June 12- 1902	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		N.C.	

13. FATHER'S NAME Thomas Jeffers

14. MOTHER'S MAIDEN NAME Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Records- ADDRESS Baltimore City Hospitals 4940 Eastern Ave.

MEDICAL CERTIFICATION

Please write clearly. Physician: please write carefully. Exact age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Far Advanced Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 10yrs. plus
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-4 , 1945 *to* 7-6 , 1949, *that I last saw the deceased alive on* 7-6 1949 *and that death occurred at* 5.10 Am, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. B. Cozzens M. D.	Baltimore City Hospitals	7-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 9 '49	Arbutus Memorial	Arbutus Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Huntington Williams, MD	Mrs Robt A Edelin & Sons	1300 N. Carlton St

VS 150

13B

G76029 ✓ G76029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Barbra Stevenson 440

2. DATE OF DEATH July 4 - 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 722 n. Spring

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 50 — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-2
D. STREET ADDRESS (If rural, give location) 722 N Spring Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	widow		62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		St Marys Co Md	

13. FATHER'S NAME Lawson

14. MOTHER'S MAIDEN NAME Coleman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Hydie Blackstone	1612 Wallace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mitral Insufficiency — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertension Arterial

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 3 1949 *to* July 4, 1949, *that I last saw the deceased alive on* July 2, 1949, *and that death occurred at* 8 10 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Edward Fisher M. D.	1612 E Monument	July 5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 8 49	Mt Calvary Cem	99 County Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Huntington Williams, M.D.	Mrs Estelle V. Elliott & Son	92 B 1129 N. Carrollton St

VS 150

Please write clearly. Physical condition is especially important. Correct age is especially important.

E 949.8

BIRTH NO. 76030

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH N-990

Registered No. 76030

1. NAME OF DECEASED (Type or Print): Frank Pilot PIELOT
2. DATE OF DEATH: JULY 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HARBOR - 1325 Boston St
c. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE: MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 2-3
D. STREET ADDRESS (If rural, give location): 1730 THAMES St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	SINGLE	?	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
COOK	TUG BOAT	AUSTRIA-POLAND	U.S.

13. FATHER'S NAME: JACOB PIELOT
14. MOTHER'S MAIDEN NAME: MARYANNA KOT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES WWI	264-26-5710	MRS. SOPHIA SLIWA	833 S. MONTFORD Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Drowning
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): harbor
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Harbor at 2325 Boston Street 1/4
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 2, 1949, 12.10 p.m.
21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Accidentally fell off boat

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7/7/49	Baltimore National	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Huntington Williams, M.D.	M. F. SADOWSKI & SONS	1808 EASTERN Ave

VS 151

186a

✓

G76031

BIRTH NO. B.C. 49-13771

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54.4 G76031

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Szumlewicz

2. DATE OF DEATH: June 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days: 1 hrs, 17 min.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 514 North Broadway 7-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	June 22, 1949			4 / 17

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Maryland	

13. FATHER'S NAME: Henry Szumlewicz

14. MOTHER'S MAIDEN NAME: Alina Herman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	The Johns Hopkins Hospital Records	

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxia

DUE TO

(B) Congenital heart disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 22, 1949, *to* June 22, 1949, *that I last saw the deceased alive on* June 22, 1949 *and that death occurred at* 9:15 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Glen G Rice M. D.	The Johns Hopkins Hospital	June 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Hoof Disposal	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Huntington Williams, M.D.		

VS 150

157E

G76032 Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

761.0

G76032 Registered No.

BIRTH NO. B.C. 20 63

1. NAME OF DECEASED (Type or Print): Ivonne Brown

2. DATE OF DEATH: June 24 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Harriet Lane

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md — COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-5
D. STREET ADDRESS (If rural give location): 1511 E. Fairmount Ave

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 6-15-49
9. AGE (In years last birthday): If Under 1 Year: Months / Days: 9 — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Brown
14. MOTHER'S MAIDEN NAME: Leelie Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Stillbirth
DUE TO
(B) Oxycephaly. ? hydrocephalus
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/20, 1949 *to* 6/24, 1949, *that I last saw the deceased alive on* 6/24, 1949, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: D B Lawson M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Hosp Disposal
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JUL 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR:
ADDRESS:

VS 150

Please write plainly. Physician: please be especially careful to record correct age in important.

161 B

Hospital Disposal

76033 B.C.H. 12781

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

b 5 G76033

b Registered No.

1. NAME OF DECEASED (Type or Print): Baby Thaxton

2. DATE OF DEATH: June 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

c. Length of stay in Baltimore: 13 hrs. 4 min. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
b-5
D. STREET ADDRESS (If rural, give location): 1743 Jefferson Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Single	June 23, 1949			13 / 4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Artie Thaxton

14. MOTHER'S MAIDEN NAME: Ruth Austin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: The Johns Hopkins Hospital Records
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Traumatic Labor and prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 23, 1949 *to* June 23, 1949 *that I last saw the deceased alive on* June 23, 1949 *, and that death occurred at* 5:47 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ben G. Rice M. D.

23B. ADDRESS: The Johns Hopkins Hospital

23C. DATE SIGNED: 6-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: Holy Cross

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JUL

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

VS 150

160a

G76034

JL - 129904

BIRTH NO. B.C.#43206

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76034

1. NAME OF DECEASED (Type or Print) Baby Boy Anderson- Janie

2. DATE OF DEATH 6-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 35 mins. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 600 Archer St. 21-2

5. SEX M

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH June 25, 1949

9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. 35

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME Janie Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT B. C. H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [ ] NO [X]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-25-49, 19__, *to* June 25, 19 49 *that I last saw the deceased alive on* June 25, 19 49 *and that death occurred at* 2.35A m., *from the causes and on the date stated above.*

23A. SIGNATURE C. A. Rogers M. D.

23B. ADDRESS 4940 Eastern Ave.

23C. DATE SIGNED 6-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremated

24B. DATE 6-30-49

24C. NAME OF CEMETERY OR CREMATORY B. C. H. Crematory

24D. LOCATION (City, town, or county) (State) 4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR JUL 7 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS

VS 150

159

Correct age is especially important. Physician: please write

AB-129797

76035
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76035
Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Johnson

2. DATE OF DEATH: 6-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Turners Station-Dundalk (Rural)
D. STREET ADDRESS (If rural, give location): 127 Chestnut St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	Negro	Single	June 20- 1949			10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Janie Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals Records- ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Meconium peritonitis
DUE TO
(B) Perforation of the illeum
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Prematurity

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES XXX NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 20- , 1949, *to* June 30- , 1949, *that I last saw the deceased alive on* June 30- 1949, *and that death occurred at* 1.15pm, *from the causes and on the date stated above.*

23A. SIGNATURE: R. B. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 7-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Cremated	7-2-1949	Baltimore City Hospitals	4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

123

G76036

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

19 6 - G76036 Registered No.

1. NAME OF DECEASED (Type or Print) RUDOLPH T. GENTILE	2. DATE OF DEATH July 5, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 705 McKewin Ave. c. Length of stay in Baltimore Yrs. Mos. Days	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 705 McKewin Ave. 9-3
5. SEX male · 6. COLOR OR RACE white · 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 24, 1904 · 9. AGE (In years last birthday) 45 yrs. · If under 1 year: Months Days · If under 24 hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur · 10B. KIND OF BUSINESS OR INDUSTRY Contracting	11. BIRTHPLACE (State or foreign country) Baltimore, Md. · 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Charles Gentile	14. MOTHER'S MAIDEN NAME Minnie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) · 16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Marguerite Gentile · ADDRESS 705 McKewin Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Jaw — INTERVAL BETWEEN ONSET AND DEATH 3 years

DUE TO

ANTECEDENT CAUSES

(B) 0

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) 0

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH; BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 19 46 *to* July 5 19 46, *that I last saw the deceased alive on* July 5 19 46, *and that death occurred at* 3 P m., *from the causes and on the date stated above.*

23A. SIGNATURE William H. Pearce M. D.	23B. ADDRESS 2105 N. Charles St	23C. DATE SIGNED July 6/46
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/8/49	24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem. · 24D. LOCATION (City, town or county) (State) Balto., Md.
DATE RECEIVED BY LOCAL REGISTRAR JUL 7 1949	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR WM. J. TICKNER & SONS · ADDRESS Baltimore, Md.

Correct age is especially important. Physician: please write clearly.

VS 150

45

G76037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 Registered No. G76037

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henry T Reutter

2. DATE OF DEATH: 5 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3002 Clifton Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3002 Clifton Ave. 15-47

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Apr. 6, 1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contractor	Real Estate	Baltimore, Md.	USA

13. FATHER'S NAME: Fritz Reutter

14. MOTHER'S MAIDEN NAME: Elise von Seggern

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	?	Mrs. Henry T. Reutter	3002 Clifton Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma, Pancreas, Head	6 Mo
	DUE TO (B) Secondary Metastasis to	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) Omentum & Liver.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
5 Jan. 1949	Metastatic lesion of omentum	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 1949 *to* July, 1949, *that I last saw the deceased alive on* 5 July 1949, *and that death occurred at* 6.40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J Bradley Daugharthy M. D.	3033 W. North Ave	6 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-8-49	Mt. Olivet	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Eustace Williams, M.D.	WM. J. TICKNER & SONS INC.	North & Pa. Aves Balto. 17, Md.

VS 150

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46 g

Exact age is especially important. Physician: please write the cause of death in plain English.

G76038 ✓ X G76038

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 2C-49-13524 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Baby Thomas Henry Cecil 768.5

2. DATE OF DEATH: July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 20 Middle River
D. STREET ADDRESS (If rural, give location): 14 Gumwood Dr

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	July 5, 1949				25	13

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore, Md.	

13. FATHER'S NAME: James Allird Cecil
14. MOTHER'S MAIDEN NAME: Mary Evelyn Mucci

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		none	Mother	14 Gumwood Dr

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Septicemia
DUE TO
(B) Prematurity
DUE TO
(C) Premature rupture of membranes

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Intra partem injection in mother

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 5, 1949 *to* July 6, 1949 *that I last saw the deceased alive on* July 6, 1949, *and that death occurred at* 2.15 p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wilfred K. Konigsberg M. D.	1211 Eutaw Place	7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/7/49	?	Frankfort, Ky

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Tunstall Williams, M.D.	WM. J. TICKNER & SONS INC.	North & Pa. Aves Balto. 17, Md.

VS 150

160c

AB-130112
76039
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76039

1. NAME OF DECEASED (Type or Print) August Miller

2. DATE OF DEATH July 6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3002 Elliott St. 1-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	White	Widowed	Jan. 18- 1879	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Blasier or Blasink Miller
14. MOTHER'S MAIDEN NAME Minnie Wagner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Baltimore City Hospitals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — Interval between onset and death: 12hrs.
DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO XXX

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 5 1949, *to* July 6- 1949 *that I last saw the deceased alive on* July 6 1949 *and that death occurred at* 6 Am., *from the causes and on the date stated above.*

23A. SIGNATURE C. S. Cogan M. D.
23B. ADDRESS Baltimore City Hospitals
23C. DATE SIGNED 7-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 9 1949
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn
24D. LOCATION (City, town, or county) (State) Catonsville Md
DATE RECEIVED BY LOCAL REGISTRAR JUL 7 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Ulbrich Funeral Home ADDRESS 2098 Eastern Ave

VS 150

94a

G76040

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

44

G76040

Registered No.

1. NAME OF DECEASED (Type or Print): Robert C. Glindemann

2. DATE OF DEATH: July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6606 Harford Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 49 Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6606 Harford Rd. 27-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Aug. 20 1872	76 77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Conrad Glindemann

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Mary Glindemann ADDRESS: 6606 Har

MEDICAL CERTIFICATION

(Physician: please write plainly. Cause of death is especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Encephalomalacia — 1 year
DUE TO
(B) Cerebral Arteriosclerosis — 3 years
DUE TO
(C) Generalized Arteriosclerosis
Nephrosclerosis
Chronic Cysto-pyelitis — 2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1947, *to* July 5, 1949 *that I last saw the deceased alive on* July 5, 1949, *and that death occurred at* 10 20 pm *from the causes and on the date stated above.*

23A. SIGNATURE: John H. Hirschfeld M.D. M. D. | 23B. ADDRESS: 6919 Harford Rd | 23C. DATE SIGNED: 7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: July 8 49 | 24C. NAME OF CEMETERY OR CREMATORY: Immanuel | 24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 7 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR | ADDRESS: L. Heemann and Son 6067 Harf. Rd.

VS 150

131a

G76041

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76041

1. NAME OF DECEASED (Type or Print) MARY ELIZABETH CURRAN

2. DATE OF DEATH July 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hosp.
C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-1
D. STREET ADDRESS (If rural, give location) 5507 Summerfield Ave.

5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 6/11/81
9. AGE (In years last birthday) 68 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Peter Dorn
14. MOTHER'S MAIDEN NAME Barbara Litz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Hospital records — ADDRESS

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of liver
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/5, 1949, *to* 7/7, 1949, *that I last saw the deceased alive on* 7/6, 1949, *and that death occurred at* 4:45 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE Thaddeus Swirnski M. D.
23B. ADDRESS St. Joseph's Hosp.
23C. DATE SIGNED 7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-11-49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) (State) Balto Md
25. FUNERAL DIRECTOR — ADDRESS Leonard J. Luck 5305 Harford

DATE RECEIVED BY LOCAL REGISTRAR JUL 7 1949 VS 150
REGISTRAR'S SIGNATURE Huntington Williams, M.D.

Correct age is especially important. Physician: please write the

46F

Dr. Eisenberg
2025 E. North

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76042

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alma A. Wurst	2. DATE OF DEATH July 6, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5718 Harford Road	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
c. Length of stay in Baltimore Yrs. Mos. Days	D. STREET ADDRESS (If rural, give location) 5718 Harford Road 27-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
female	white	widowed	Apr. 21, 1855	94				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltim re, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John F. Bruckner	Julia A. Graeser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
			Miss Elsie Wurst, 5718 Harford Road

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Gangrene Right Foot	10 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Cardio Vascular Renal Disease	3 years
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 7, 1949, *to* July 6, 1949, *that I last saw the deceased alive on* July 5, 1949, *and that death occurred at* 6:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert Eisenberg, M. D.	2025 E North Ave	7-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-9-49	Baltimore	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 7 1949	Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

VS 150

Correct age is especially important, physician please.

131a

G76043

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

20-1 G76043 Registered No.

1. NAME OF DECEASED (Type or Print) William Riberkof

2. DATE OF DEATH July 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3627 Lucille Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 60 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3627 Lucille Ave 27-18

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widower	1876	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Motion Picture Operator		Russia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Morris Riberkof	Dora ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Israel Rivers	3022 Auchentoroly Terrace

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Thrombosis	1 day
ANTECEDENT CAUSES	DUE TO (B) Hypertensive C.V. Disease	8 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Bronchial Asthma	10 years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 18, 1945, *to* July 7, 1949, *that I last saw the deceased alive on* July 7, 1949, *and that death occurred at* 6:15 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Manuel Levin M. D.	4818 Reisterstown Rd	July 7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 8, 1949	Hebrew Washington Rd	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Tuttle Storr Williams, M.D.	Sol Levinson & Bros	1126 W North Ave

VS 150

Correct age is especially important. Physician: please write the

939

G76044 ✓ G76044

BALTIMORE CITY HEALTH DEPARTMENT 151 Registered No.

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna T. Dey

2. DATE OF DEATH: July 5th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1735 N. Washington St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 8-6
D. STREET ADDRESS (If rural, give location) 1735 N. Washington St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: June 13th, 1873
9. AGE (In years last birthday): 76
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John J. Connolly
14. MOTHER'S MAIDEN NAME: Elenor Kennedy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Miss Irene Connolly ADDRESS: 1735 N. Washington

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastases and Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 30 days

DUE TO

(B) Carcinoma of Stomach and Intestines — 1 year

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* January 6, 1949, *to* July 5, 1949, *that I last saw the deceased alive on* ____ 19____, *and that death occurred at* 1515 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Albert Eisenberg M. D.
23B. ADDRESS: 2025 E North Ave
23C. DATE SIGNED: 7-7-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/8/49
24C. NAME OF CEMETERY OR CREMATORY: Nat'l Cathedral
24D. LOCATION (City, town or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 7 1949
REGISTRAR'S SIGNATURE: Washington Williams M.D.
25. FUNERAL DIRECTOR: E. J. Fanning & Son
ADDRESS: 1936 E. Lafayette Ave.

VS 150

46 B

Correct age is especially important. Physician: please write

G76045

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

31 G76045

Registered No.

1. NAME OF DECEASED (Type or Print): Hattie B. Royal Smith

2. DATE OF DEATH: July 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1612 McKean ave

c. Length of stay in Baltimore: 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-2
D. STREET ADDRESS (If rural, give location): 1612 McKean Ave

5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: 6/14/901
9. AGE (In years last birthday): 48
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Brice Va
12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME: Benjamin Royal
14. MOTHER'S MAIDEN NAME: Fannie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Simmel Smith ADDRESS: 1604 Edmondson Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

DUE TO

(B) Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 3 1949, *to* July 4 1949, *that I last saw the deceased alive on* July 3 1949, *and that death occurred at* 7-45a m., *from the cause and on the date stated above.*

23A. SIGNATURE: Bruce U. Benjamin M. D.
23B. ADDRESS: 1834 Edmondson Ave
23C. DATE SIGNED: 7/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/9/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph A. Lucky ADDRESS: 661 W Barre St

83a

Correct age is especially important. Typewrite or print plainly in ink.

G76046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178

G76046

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Harry H. Mullen

2. DATE OF DEATH: July 5-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2228 Jefferson St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 7-3
D. STREET ADDRESS (If rural, give location): 2228 Jefferson St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Oct. 6-1899	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist Helper	Western Md. R.R.	Md.	

13. FATHER'S NAME: Wm. Mullen

14. MOTHER'S MAIDEN NAME: Barbara Runscheimer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
Yes	World War I	

17. INFORMANT: Alberta Mullen ADDRESS: 2228 Jefferson St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized carcinomatosis DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma Testicle DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Carcinoma of rt. testicle	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 19 49 *to* 7-5, 19 49, *that I last saw the deceased alive on* 7-5, 19 49, *and that death occurred at* 10:24 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sam Vogel M.D.	720 E. Howard St	7-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 8-1949	Baltimore Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Huntington Williams, M.D.	John A. Heller	2334 Jefferson St.

VS 150

51C

Do not age is especially important. Typewrite.

G76047

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 G76047

Registered No.

1. NAME OF DECEASED (Type or Print) Johannah Lehmitt

2. DATE OF DEATH July 6 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY 8-3
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1302 N Lexington St Home of Our Lady

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2508 E. Biddle St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Sept. 17-1869	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Balto. Md.	

13. FATHER'S NAME Wagner

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS
Barbara M. Carey 2508 E. Biddle St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: One day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio-Vascular disease — ?

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1, 1949, *to* July 6, 1949, *that I last saw the deceased alive on* July 6, 1949, *and that death occurred at* 4:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Glassman M. D.	753 W. Fayette St	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 9/49	Holy Redeemer Cem.	Belair Rd. Md

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE [redacted] — 25. FUNERAL DIRECTOR — ADDRESS
JUL 7 1949 — John L. Miller — 2334 Jefferson St.

93D

Correct age is especially important. Typewriter preferred.

G76048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 917.° G76048

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HENRIETTA SOPHIA EGAN N 949.2

2. DATE OF DEATH July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-2

c. Length of stay in Baltimore 45 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 128 Rochester Place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	2-4-83	66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Md.	USA

13. FATHER'S NAME Henry Kinnecker

14. MOTHER'S MAIDEN NAME Anna Krakey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		none

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

(Effect age is especially important. Physician, please ...)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Third degree burn 30% of body surface.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma breast with Cerebral metastases.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
A. H. Merrill M. D.
CHIEF OR ASST. PHYSICIAN-EXAMINER

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	home	128 Rochester Place 1/2

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
6-29-49 Noon	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Drug ingestion from ...

22. I hereby certify that I attended the deceased from 6/29, 1949 to 7/5, 1949 that I last saw the deceased alive on 7/5, 1949, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Gordon Malone Carver Jr. M. D.	JOHNS HOPKINS HOSPITAL	7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/7/49	Mount Olivet Cem.	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 7 1949	[illegible] for A. H. Williams M.D.	HENRY SANDER & SONS, INC. BALTIMORE - 13, MARYLAND

VS 150

181

G76049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16 V G76049 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George A. Hopkins

2. DATE OF DEATH July 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Md. General Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

c. Length of stay in Baltimore 6 6 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore City
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) 1-1
D. STREET ADDRESS (If rural, give location) 3042 Dillon Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	Sept 14, 1882	66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist

10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James F. Hopkins

14. MOTHER'S MAIDEN NAME Clara McCormick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-07-9079

17. INFORMANT Mrs Mary Wille ADDRESS 4613 Arabia Ave.

MEDICAL CERTIFICATION

(Physician: please write plainly. Correct age is especially important.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Insanition & respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: Progressive for about one month

DUE TO

(B) metastatic mediastinal nodes

DUE TO

(C) Carcinoma of lung Bronchiogenic. c metastases — Known about 2 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis, generalized 2° anemia

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-27 1949 *to* 7-6 1949, *that I last saw the deceased alive on* 7-6 1949, *and that death occurred at* 8:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE Marguerite Louise Cadle M. D. | 23B. ADDRESS Md. General Hospital | 23C. DATE SIGNED July 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/9/49	Loudon Park Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 7 1949 | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC

VS 150

Huntington-Williamsport, Md.

BALTIMORE - 13, MARYLAND 47c

G76050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1 53

G76050

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): George Louis Deichmann

2. DATE OF DEATH: July 6 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 514 N. Chapel Gate Lane

c. Length of stay in Baltimore: 65 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-4
D. STREET ADDRESS (If rural, give location): 514 N Chapel Gate Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M.	W.	Widower	May 7 1870	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dentist	Retired	Bristol Tenn.	

13. FATHER'S NAME: Edward Deichmann

14. MOTHER'S MAIDEN NAME: Mary Kuehnert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Spanish american		Geo L Deichmann Jr	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of lung, metastatic — INTERVAL BETWEEN ONSET AND DEATH: about 6 months

DUE TO

(B) Carcinoma of G-I. tract — unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

arteriosclerotic heart disease — 6 years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb, 1947, *to* July 6, 1949, *that I last saw the deceased alive on* July 6, 1949, *and that death occurred at* 11:10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo J. Gara M. D.	1 Mallow Hill Ave	7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 8/49	Druid Ridge	Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Huntington Williams, M.D.	Henry W. Jenkins & Sons Co	4925 York Rd

VS 150

46M

Collect age is especially important. Physician, please

BIRTH NO. 1 G76051

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76051 Registered No. 331

1. NAME OF DECEASED (Type or Print): MARY AGNES KENNEDY

2. DATE OF DEATH: JULY 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4809 CROWSON AVE.
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 27-11
D. STREET ADDRESS (If rural, give location): 4809 CROWSON AVE

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 4-11-1877
9. AGE (In years last birthday): 72 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): BALTO, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JAMES KENNEDY
14. MOTHER'S MAIDEN NAME: MARY J. BIRT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: J.M. KENNEDY ADDRESS: 805 BEAUMONT AV.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 mth
DUE TO
(B) Arteriosclerosis — 10 yrs
DUE TO
(C) Chron Interstitial Nephritis — 10 yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 2, 1949 to July 6, 1949, *that I last saw the deceased alive on* July 1, 1949, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: G. F. Bishop M. D.
23B. ADDRESS: 503 Sheridan Ave
23C. DATE SIGNED: July 6 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 7-9-1949
24C. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL
24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Certified from Baltimore, Md.
25. FUNERAL DIRECTOR: H.W. JENKINS & SONS CO.
ADDRESS: 4905 YORK RD.

VS 150

131a

G76052 — 14 — 155 — G76052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Margaret A. Gravel

2. DATE OF DEATH: 7 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland —

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: 44 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): [redacted]e Towson
D. STREET ADDRESS (If rural, give location): 28 Anstree Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	26 Aug. 1904	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Balto, Md.	U.S.

13. FATHER'S NAME: Marion A. Slinton

14. MOTHER'S MAIDEN NAME: Rosa M. Sabaccaro

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Deceased	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Primary Carcinoma of Liver — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

ANTECEDENT CAUSES

(B) —

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) —

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchiectasis, left upper lobe — 10 years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3 July, 1949, *to* 7 July, 1949, *that I last saw the deceased alive on* 7 July, 1949, *and that death occurred at* 3:10 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. F. Cox 3rd M. D.	Union Memorial Hospital	7 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 9/49	Parkwood	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949 VS 150	Transcription from Baltimore, Md.	Henry H. Jenkins Sons Co	4905 York Rd.

Correct age is especially important. Physicians: please write plainly.

46F

G76053

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. G76053

1. NAME OF DECEASED (Type or Print) Pearl Pleasants

2. DATE OF DEATH July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore 18 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-2
D. STREET ADDRESS (If rural, give location) 709 N. Spring St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	2-12-12	37		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Bird Booker	Mary Hennick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension

(C) Scleroderma

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	JOHNS HOPKINS HOSPITAL

22. *I hereby certify that I attended the deceased from* 6-18, 1949 *to* 7-5, 1949 *that I last saw the deceased alive on* 7-5, 1949 *and that death occurred at* 10 20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William W. Winternitz M. D.	Johns Hopkins Hospital	7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 9-1949	Mt Calvary Cem.	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Huntington Williams, M.D.	Elroy O. Wilson	1010 Bentz

VS 150

Do not age is especial importance. Physicians please

83a

G76054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

Registered No. G76054

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET ONeill

2. DATE OF DEATH 7-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3535 Old York Rd

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 9-3

D. STREET ADDRESS (If rural, give location) 3535 Old York Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Sept. 29, 1862	86 87				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Ireland	

13. FATHER'S NAME
PATRICK T. TEEVAN

14. MOTHER'S MAIDEN NAME
ANN HAGUE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			MRS. JAMES J. Kelly	3535 Old York Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility

DUE TO

(B) Arteriosclerosis

DUE TO

(C) Cardio-vascular-renal disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* [illegible], 1946 *to* 7-5, 1949 *that I last saw the deceased alive on* 7-4, 1949 *and that death occurred at* 7:20 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. Kwalff. M. D.	36 York Ct.	7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-8-49	New Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Huntington for Matthews, M.D.	John A. Moran	3900 E. Balt. St.

VS 150

1319

Important: Physician, please complete age is especially

76055

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 31

G76055 Registered No.

1. NAME OF DECEASED (Type or Print) WILLIAM ALFRED NAIRN' BOWLAND

2. DATE OF DEATH July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HOME: 3507 N. Charles Street

c. Length of stay in Baltimore 7 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) City of Baltimore
D. STREET ADDRESS (If rural, give location) 3507 N. Charles Street 12-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Nov. 12, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Broker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Kingston, Somerset Co., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Levin Edwin Pollitt Bowland

14. MOTHER'S MAIDEN NAME Evelyn Cathell Hayman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 214-20-9084

17. INFORMANT (widow) ADDRESS Mrs. Elizabeth R. W. Bowland 3507 N. Charles

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Vascular accident	2 hours
DUE TO (B)	arteriosclerosis, Hypertension	10 years
DUE TO (C)	Peptic ulcer	15 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1946, *to* July 5, 1949, *that I last saw the deceased alive on* June 30, 1949, *and that death occurred at* 11P m., *from the causes and on the date stated above.*

23A. SIGNATURE Francis W Huck M. D. — 23B. ADDRESS 3406 St Paul St — 23C. DATE SIGNED 7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE July 9, 1949 — 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. — 24D. LOCATION (City, town, or county) (State) Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 7 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Company - 108 W. North Ave. Balto. - 1, Md.

VS 150

Correct age is especially important. Physician, please write plainly.

83a

AB-114835
76056

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G76056

1. NAME OF DECEASED (Type or Print): Lee Tune

2. DATE OF DEATH: July 6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 2yrs ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-1
D. STREET ADDRESS (If rural, give location): 312 Park Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	Chinese	Married	?-?-?	76?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
? retired	? retired	China	

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	No	None	Baltimore City Hospitals Records-4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-28-[illegible], 1947, *to* 7-6-, 1949 *that I last saw the deceased alive on* 7-6- 1949, *and that death occurred at* 8 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
P. L. Rozen M. D.	Baltimore City Hospitals	7-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 5/49	Lorraine Park Cems.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Tenney Johnson Williams, M.D.	Stewart & Mowen Co.	108 W. North Ave. 937 Balto. #1, Md.

VS 150

Please print. Type if possible. Be sure every item is complete. Exact age is especially important.

AB-130111
G76057
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 443
Registered No. G76057

1. NAME OF DECEASED (Type or Print): George Kroner

2. DATE OF DEATH: July 6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Baltimore County Essex
D. STREET ADDRESS (If rural, give location): Rt. 16-Box 297 -Essex,Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Sept-26- 1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Kroner
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records- ADDRESS: Baltimore City Hospitals 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular Accident
DUE TO
(B) Hypertensive Cardio Vascular Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-5- , 1949 *to* 7-6- , 1949, *that I last saw the deceased alive on* 7-6- , 1949, *and that death occurred at* 5.30 AM *from the causes and on the date stated above.*

23A. SIGNATURE: L. S. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 7-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-9-49
24C. NAME OF CEMETERY OR CREMATORY: Zion Lutheran
24D. LOCATION (City, town, or county) (State): Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John G. Connelly ADDRESS: 418 Eastern Ave

937 Balto 21 Md

VS 150

correct age is especially important. Physician, please

STRAWDER

G76058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53 Registered No. G76058

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Walter Strawder

2. DATE OF DEATH July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1732 E. Preston st 8-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Married	5-7-99	50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME Walter Strawder

14. MOTHER'S MAIDEN NAME Elizabeth Nash

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of sigmoid, carcinomatosis	App. 1 year.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-2-49	Carcinomatosis, carcinoma of sigmoid colon	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 7-1 1949, to 7-6 1949, that I last saw the deceased alive on 7-6 1949, and that death occurred at 4 P. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dwight C. McLean M. D.	JOHNS HOPKINS HOSPITAL	7-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 9/49	Mt Calvary Cem	B. C. County Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 7 1949	Huntington Williams, M.D.	Mrs Scott A. Elliott Dft. 1129 N. Carlin St.

VS 150

46E

Cause of age is especially important. Physicians, please

Medical Ex.'s case released 7/20/49 ✓ 76039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76059

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Dora Young**

2. DATE OF DEATH **July 5, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **St. Joseph's Hospital**
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) **Balto.**
D. STREET ADDRESS (If rural, give location) **1013 Stirling St.** 10-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	Colored	Widow	Nov 23, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore	

13. FATHER'S NAME **unknown**

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Clara Roberts	1005 Eagle St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) **Acute coronary thrombosis**
DUE TO
(B) **Hypertensive arteriosclerotic**
DUE TO **heart disease**
(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. **Pulmonary oedema, acute**

CERTIFICATION APPROVED BY

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **July 5,** 19**49** *to* **July 5,** 19**49** *that I last saw the deceased alive on* **July 5,** 19**49** *and that death occurred at* **4:30** *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. K. Kaan M. D.	1400 N. Caroline St.	July 5, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 8/49	Arbutus Memorial Park	Arbutus Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Evington Williams, MD	Mrs Ruth A. Elliott Dougette	931 1129 N. Caroline St.

VS 150

Correct age is especially important. Hypertens[illegible]

Harry Kleinowitz — Gloria Kleinowitz
C. Kleinowitz — Gloria Kleinowitz

G76060 BALTIMORE CITY HEALTH DEPARTMENT G76060

BIRTH NO. **CERTIFICATE OF DEATH** 160 Registered No.

1. NAME OF DECEASED (Type or Print): Harry Kleinowitz

2. DATE OF DEATH: July 4th, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3208 Elliott St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

c. Length of stay in Baltimore: Yrs. — Mos. — Days —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3208 Elliott St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Male	W	M	Not Known	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Iron Worker

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ? Kleinowitz

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Un

(If yes, give war or dates of service): Un

16. SOCIAL SECURITY NO.: 214-01-6397

17. INFORMANT: Anna M. Kleinowitz ADDRESS: 3208 Elliott St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Left Antrum — INTERVAL BETWEEN ONSET AND DEATH: 9 Months

DUE TO —

ANTECEDENT CAUSES

(B) —

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO —

(C) —

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 2 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 29, 1949 *to* July 4, 1949 *that I last saw the deceased alive on* July 2, 1949 *and that death occurred at* 6 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Grafton Harper M. D.	214 Med. Arts Bldg.	7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 8-49	Holy Trinity Russian	Elkridge Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Huntington Williams M.D.	John A. Gerbauckas Jr	1905 E. Pratt St 55

VS 150

G76061 — BALTIMORE CITY HEALTH DEPARTMENT — G76061

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): FRANK GORLEY

2. DATE OF DEATH: July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 649 West Fayette Street 4-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	Nov. 28, 1883	65	7	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
carpenter		Fountaindale, Pennsylvania	

13. FATHER'S NAME: Charles Gorley

14. MOTHER'S MAIDEN NAME: Amanda Kline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mr. Walter Y. Grove, Waynesboro, Pa.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: July 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	July 7 1949	Waynesboro Penna	Waynesboro Penna

DATE RECEIVED BY LOCAL REGISTRAR: JUL 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Wm. J. Tschner & Son Fayette & Calvert

correct age is especially important. Physicians, please write plainly.

93 Balto 17 mal

G76062 G76062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES H. THOMPSON

2. DATE OF DEATH 7/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 719 Dolphin ST

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 719 Dolphin St. 12-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	Married	7/20/1880	68	11	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waiter	Resturant	Balto. Md	U.S.A.

13. FATHER'S NAME James A. Thompson

14. MOTHER'S MAIDEN NAME Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	219-05-7885	Annie Thompson (W)	719 Dolphin St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO

(B) Arter Sclerosis — 2 yr

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
Dr. Robert B. McFadden
M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____ 19__ *and that death occurred at* 12.30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Atwell Jones M. D.	5-3-4 Rolph	7.6.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/7/49	Mt. Auburn	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Huntington Williams, M.D.	Charles G. Cooper	512 Carrollton Av.

VS 150

131a

G76063

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. G76063 Registered No. 57

1. NAME OF DECEASED (Type or Print): EDWARD GANDY GASKILL

2. DATE OF DEATH: July 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore: 31 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: NJ
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Port Norris
D. STREET ADDRESS (If rural, give location): High Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	W	Married	5/8/83	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Master	Seafarer	NJ	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Elcanis Gaskill	Lovina Hickmann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
Unknown	Unknown	Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of pancreas — Interval between onset and death: 3 mos.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 6, 1949, *to* July 7, 1949, *that I last saw the deceased alive on* July 7, 1949, *and that death occurred at* 11:26 AM, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James B. Dukes M.D.	US Marine Hospital, Balto, Md.	7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removed	7/7/49	Overlook	Audubon N.J.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JUL 7 1949	Hamilton Williams, M.D.	William J. Doe 1217 Eutaw St.

VS 150

469

Do not use this space. Important. Legible.

G76064

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76064 Registered No.

1. NAME OF DECEASED (Type or Print): Charles John Zeltner

2. DATE OF DEATH: JUL 7 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa
B. COUNTY: Lwedesburg
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bridgeport
D. STREET ADDRESS (If rural, give location): 13 Center St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	S.	7.6.47	2	11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Pa	

13. FATHER'S NAME: Charles Zeltner

14. MOTHER'S MAIDEN NAME: Nellie Posobrie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tetralogy of Fallot — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

DUE TO

(B) Congenital cardiac anomaly
DUE TO cx failure.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/27/49	Tetralogy of Fallot	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-31 1949 *to* 7-7 1949, *that I last saw the deceased alive on* 7-7 1949, *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William R. Nelson M. D.	JOHNS HOPKINS HOSPITAL	7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/7/49	St. Augustines	Bridgeport - Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Thurlington Williams, M.D.	Ullmer Funeral Home	2007 Eutaw St

VS 150

157E

BIRTH NO. G760:5

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G760:5

1. NAME OF DECEASED (Type or Print): Donald Sadika

2. DATE OF DEATH: July 7 49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Adah.
D. STREET ADDRESS (If rural, give location): Box 279

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	—	1-27-46	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Pa.	

13. FATHER'S NAME: Joseph Sadika

14. MOTHER'S MAIDEN NAME: Agnes Zagar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease (Probable cor trilocularae) — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

(B) trilocularae

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/6/49	Malvea	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 5, 1949 *to* July 7, 1949 *that I last saw the deceased alive on* July 7, 1949 *and that death occurred at* 11:03 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert L. Nelson M. D.	JOHNS HOPKINS HOSPITAL	7-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/7/49	Toney Funeral Home	Mason Town Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 7 1949	Thomas J. Williams, M.D.	Earl B. Wharton	403-E 25th St.

VS 150

157E

G76066 BALTIMORE CITY HEALTH DEPARTMENT G76066

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) Waverly Paige

2. DATE OF DEATH July 5 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore -
D. STREET ADDRESS (If rural, give location) 1614 E. Chase St. 8 07

5. SEX Male | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 10-19-01 | 9. AGE (In years last birthday) 47 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Va. - | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Billy Paige

14. MOTHER'S MAIDEN NAME Mary Cole

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Arteriolar nephrosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 14 1949 to July 5 1949, *that I last saw the deceased alive on* July 5 1949, *and that death occurred at* 9 35 a m., *from the causes and on the date stated above.*

23A. SIGNATURE David Sukeus M. D. | 23B. ADDRESS JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Shipped | 24B. DATE July 7-49 | 24C. NAME OF CEMETERY OR CREMATORY Farmville Va | 24D. LOCATION (City, town, or county) (State) Virginia Va

DATE RECEIVED BY LOCAL REGISTRAR JUL 7 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Rayner Sanders ADDRESS 1412 E. Preston St

conduct age is important. Physician: Please

131a

✓ E-985 × G76067

G76067

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 76067

N-805.0

1. NAME OF DECEASED (Type or Print): Howard Andrew Fram

2. DATE OF DEATH: July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Penitentiary 954 Forrest St.
c. Length of stay in Baltimore: 3 Yrs. 28 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Montgomery
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kensington
D. STREET ADDRESS (If rural, give location): Plyars Mill Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	7-1-1916	33				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Painter
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Dayton, Ohio
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Ninion Fram
14. MOTHER'S MAIDEN NAME: Viola West
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): -
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 219-01-2515
17. INFORMANT: - ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Dislocation of 5th Cervical Vertebrae
DUE TO
(B) Execution by hanging
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-10- 1948 *to* 7-8- 1949, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 12:42 AM *from the causes and on the date stated above.*

23A. SIGNATURE: Henry H. Hollis
23B. ADDRESS: Maryland Penitentiary
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-8-49
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill
24D. LOCATION (City, town or county) (State): P.G. Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR: 7-8-49
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Albert J. Ashe
ADDRESS: 1431 Potomac Ave. S.E. Washington D.C

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G76068

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Vol. 1 G76068 Registered No.

1. NAME OF DECEASED (Type or Print) Minna Mendelssohn

2. DATE OF DEATH 7/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
332 Whitridge Ave

c. Length of stay in Baltimore — Yrs. Mos. Days: 1-2-03

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 332 Whitridge Ave

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Widowed	Dec 21st 1859	89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Bruna Germany	

13. FATHER'S NAME (Unknown) Dorn

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Felix R. Mendelssohn	332 Whitridge Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) coronary sclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1945, *to* , 1949 *that I last saw the deceased alive on* 6/25, 1949, *and that death occurred at* 6 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harold H. Bix M. D.	2516 Linden Ave	7-7-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/9/49	Chevra Shalom	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 8 1949

REGISTRAR'S SIGNATURE: [illegible] Baltimore, Md.

25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 127 St. Paul St

VS 150

94a

G760.9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G760.9

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SARAH E. MUSGRAVE

2. DATE OF DEATH July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
16 W. West Street

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 16 West West Street 2 3 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Widowed	Oct 17th 1874	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Balto. Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jack Willis	Mare C. Kirkwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Clara Nelson	16 W. West St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-

DUE TO Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
William J. McClafferty M.D.		July 6, 1949

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/8/49	Holy Cross	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, MD	Wm Cook Inc	1217 St. Paul St.

correct age is especially important. Physicians, please make

VS 151

937

7607.0

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G7607.0

Registered No.

1. NAME OF DECEASED (Type or Print) MR. NORMAN RALPH COOPER SR.

2. DATE OF DEATH 7 JULY 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore — Yrs. / Mos. / Days: DURATION OF LIFE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 18
D. STREET ADDRESS (If rural, give location): 2946 GREENMOUNT AVENUE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	MARRIED	JULY 25, 1897	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STEAMFITTER

10B. KIND OF BUSINESS OR INDUSTRY: Board of Housing Grounds

11. BIRTHPLACE (State or foreign country): BALTIMORE

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM GEORGE COOPER

14. MOTHER'S MAIDEN NAME: MARGARET COLLISON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): UNKNOWN

16. SOCIAL SECURITY NO. 216-01-7827

17. INFORMANT: PT. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: ABOUT 2 WKS.

DUE TO

(B) HYPERTENSIVE VASCULAR DISEASE — YEARS

DUE TO

(C) Arteriolar nephro-sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [Y] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 29 JUNE, 1949, *to* 7 JULY, 1949, *that I last saw the deceased alive on* 7 JULY, 1949, *and that death occurred at* 2:45 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Chanler Stanbeal M. D.	Union Memorial Hospital	7 JULY 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
Burial	7/9/49	London Park	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 127 St. Paul St.

VS 150

131a

Print or type all entries. Items must be answered or line must be marked (—) if not applicable. Correct age is especially important. Physician: please complete items 18 to 22.

76071

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

41

G76071

Registered No.

1. NAME OF DECEASED (Type or Print) CLIFFORD H. FORSYTHE

2. DATE OF DEATH July 7th-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
St Paul & 22nd St
Beck Diagnostic Clinic

c. Length of stay in Baltimore 12 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 4810½ Belair Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year Months	If under 1 year Days	If under 24 hours Hours	If under 24 hours Min.
male	white	married	June 28th. 1897	52		9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Expediter	Pa. R.R.	Pa.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Walter L. Forsythe	Carrie Hoy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no	716-10-9670	Mrs. C.H. Forsythe	4810½ Belair Raod

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
(A)	Heat Exhaustion	3 days
DUE TO		
(B)	Chr. Bacterial asthma	many years
DUE TO		
(C)	Inanition, Exhaustion psychosis	

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 26th 1949 *to* July 7 1949, *that I last saw the deceased alive on* July 7, 1949, *and that death occurred at* 12:30A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathaniel M Beck M. D.	100 E 22nd St	July 8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/9/49		Northumberland, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	Lasocki Funeral Home	7401 Belair Rd.

VS 150

112

G76072 BALTIMORE CITY HEALTH DEPARTMENT 200.1 G76072

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rivas, Octavio

2. DATE OF DEATH July 2, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New York. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) New York City
D. STREET ADDRESS (If rural, give location) 790 E 161st St.,

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S.Marine Hospital

c. Length of stay in Baltimore 27 Yrs. Mos. 1 Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year Months	Days	If under 24 hours Hours	Min.
m	W	Div.	May 25, 1904	45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
waiter	TCUSA - on ship	Puerto Rico	- - -

13. FATHER'S NAME: Delfin Rivas

14. MOTHER'S MAIDEN NAME: Secondo Rivas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unk	- - -	103 05 2039	U.S.Marine Hospital	Balto., Md.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lymphosarcoma

DUE TO (B) Reticulum cell sarcoma of left cervical lymph node

DUE TO (C) Extension of bronchial pulmonary

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Unknown

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 5, 1949 *to* July 2, 1949 *that I last saw the deceased alive on* July 2 1949 *and that death occurred at* 10:1Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M. D.	U.S. Marine Hospital, Balto., Md	7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-8-49	St Peters	Baltimore City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Thurlington for Williams, M.D.	Chas B Wolcott	403-E-25th St.

Correct age is especially important. Typewrite or print plainly.

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55E

AB-66389
78073

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

143 G760.73

Registered No.

1. NAME OF DECEASED (Type or Print) Bernard Schoberg

2. DATE OF DEATH July 5-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 723 W.Lexington St. 4-0 V.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
M	W	Single	Jan. 2- 1873	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Engraver Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Herman Schoberg

14. MOTHER'S MAIDEN NAME Theresa Trenton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Baltimore City Hospitals Records--4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Vascular Hemorrhage	24hrs.
	DUE TO (B) Hypertensive Arteriosclerotic	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO Cardio Vascular Disease	8yrs.
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Congestive Heart Failure	1yr.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-28 , 1941, *to* 7-5- , 1949 *that I last saw the deceased alive on* 7-5- , 1949 , *and that death occurred at* 2.30P m., *from the causes and on the date stated above.*

23A. SIGNATURE R. L. Rogers M. D.

23B. ADDRESS Baltimore City Hospitals

23C. DATE SIGNED 7-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~or CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	7/9/49	Holy Cross	Annapolis Road

DATE RECEIVED BY LOCAL REGISTRAR JUL 8 1949

REGISTRAR'S SIGNATURE Huddleston Williams, M.D.

25. FUNERAL DIRECTOR AND ADDRESS H. W. Mears and Son 705 N. Calvert St.

VS 150

93D

G760.4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

G760.4

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) WILLIAM NASH

2. DATE OF DEATH July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 118 N Mount St.

C. Length of stay in Baltimore 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 118 N Mount St. 19 ward

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored	Widower	Oct. 1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Va.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Not known	Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Herman Nash	118 N Mount St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular ? — INTERVAL BETWEEN ONSET AND DEATH

DUE TO Disease

(B) Hypertension — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Senility, Arteriosclerosis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 23, 1949 *to* July 6, 1949 *that I last saw the deceased alive on* 7/2, 1949 *and that death occurred at* 3:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. Wallis Shevington M.D.	201 N Caroline St.	7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Mt. Auburn	July 9th	Mt. Auburn	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	A. Jones	501 Orleans Road

VS 150

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10K

760.75
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 0 0

G760.75
Registered No.

1. NAME OF DECEASED (Type or Print): McDonald Raymond
2. DATE OF DEATH: 7/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1519 Division
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: Life 32 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anarundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glen-Burnie - P.O. #215
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	married	12/2/97	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Lumber Yard	Glen Burnie	

13. FATHER'S NAME: William H McDonald
14. MOTHER'S MAIDEN NAME: Maude Cole

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	—	

17. INFORMANT: Maude McDonald — ADDRESS: Glenburnie Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Failure
DUE TO
(B) Hypertensive Cardiovascular Disease
DUE TO
(C) Subacute bacterioendocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Gangrene of left foot

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/15 19 49, *to* 7/5 19 49, *that I last saw the deceased alive on* 7/5/49 19 ___, *and that death occurred at* 9 05 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr Maxens W. Moore Sr M. D.	Provident Hospital	7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/10/49	Mt Calvary	A. A. Co., Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	J. L. Brown & Son	108 W Montgomery St

VS-150

93D

760'76

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G760'76

Registered No.

1. NAME OF DECEASED (Type or Print) Thomas Taylor

2. DATE OF DEATH 7/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 938 W. Franklin Street

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, City
D. STREET ADDRESS (If rural, give location) 938 W. Franklin Street 16-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	C	W	2/9/1874	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Self Employed	General Store	Baltimore, City	

13. FATHER'S NAME Thomas Taylor

14. MOTHER'S MAIDEN NAME Sarah Meyers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT — ADDRESS: Estelle Taylor-938 W. Franklin, St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocardetis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Hypertension Nephritis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/4, 1948, *to* 7/4, 1949, *that I last saw the deceased alive on* 7/4, 1949, *and that death occurred at* 3-P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dan Brandeen M. D.	1122 W See St	7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/8/49	Mt Auburn Cemetery	Baltimore, City.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	D. L. Brown & Son 108 W	Montgomery St

VS 150

937

760.7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

Registered No. 760.7

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Albert Jenefer

2. DATE OF DEATH July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1742 N. Calhoun Street

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1742 N. Calhoun Street 15-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	May 1, 1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nightwatchman		St. Mary Co. Md.	U.S.A.

13. FATHER'S NAME
William Jenifer

14. MOTHER'S MAIDEN NAME
Eliza Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		212-14-1325	Mrs. Lucy C. Jenefer	N. Calhoun St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma (gastric) — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 16 *to* July 6, 1949 *that I last saw the deceased alive on* 7-6-1949, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George C. Page M. D.	1816 N. Mount St.	7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/9/1949	St. Peters	Baltimore, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 8 1949	Turlington Williams, M.D.	Holland Funeral Home 1631 Druid Hill Ave.

VS 150

46B

BIRTH NO. 760.78

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 760.78

1. NAME OF DECEASED (Type or Print) HANNAH EUBANKS

2. DATE OF DEATH July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident hospital

C. Length of stay in Baltimore 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2564 McCulloh Street 13-63

5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH June 12, 1887
9. AGE (In years last birthday) 79 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Mecklenburg, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Tiney Daves

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Pattie Montague ADDRESS 2564 McCulloh St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 1 wk
DUE TO
(B) Myocardial Arch Disease & Hbp.
DUE TO
(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1949 *to* July 6, 1949, *that I last saw the deceased alive on* July 6, 1949, *and that death occurred at* m. *from the causes and on the date stated above.*

23A. SIGNATURE Graham Higgins M. D.
23B. ADDRESS 2243 Madison Ave
23C. DATE SIGNED 7-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/10/1949
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn
24D. LOCATION (City, town, or county) Baltimore, Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 8 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Holland Funeral Home
ADDRESS 1631 Druid Hill Ave.

VS 150

93

G760.79

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G760.79 Registered No.

1. NAME OF DECEASED (Type or Print): Mary Harriett Douglas
2. DATE OF DEATH: July 6, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) 15-0
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1509 N. Pulaski St.
C. Length of stay in Baltimore: Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 1509 N. Pulaski St.
5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Oct. 20, 1863
9. AGE (In years last birthday): 85
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Snow Hill, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Albert Nearing
14. MOTHER'S MAIDEN NAME: Hester Dennis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no, or unknown): No.
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Miss Anna Douglas ADDRESS 700 E. Camden St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Heat Exhaustion — INTERVAL BETWEEN ONSET AND DEATH: 6 Hrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B) Chronic Myocarditis — 10 Yrs.
DUE TO (C) Arteriolsclerosis — 10Yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 48 *to* July 6, 1949 *that I last saw the deceased alive on* July 6, 1949 *and that death occurred at* 5:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: William C. Polk, M. D.
23B. ADDRESS: 1506 Penna. Av.
23C. DATE SIGNED: 7.6.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 9/1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Plc.
24D. LOCATION (City, town, or county) (State): Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 150

937

G76080

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

#43 G76080 Registered No.

1. NAME OF DECEASED (Type or Print): ANNIE WILLIAMS TURNER

2. DATE OF DEATH: July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1525 Edmondson Ave. 19 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow	March 5, 1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Orange Co. Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Armstead Williams	Louisa ??????

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.			Mr. Howard Turner	~~1525~~ Edmondson Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 months
DUE TO
(B) Arteriosclerosis — 2 yrs
DUE TO
(C) Hemorrhage (Cerebral) & Breast — 1 month

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-27-49, 19__, *to* 7-5-49, 19__, *that I last saw the deceased alive on* 7-5-49, 19__, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Theodore Stigant M. D.	2113 Madison Ave	7-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/8/1949	Arbutus Mem. Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave.

VS 150

93D

BIRTH NO. 376081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No. D176851

1. NAME OF DECEASED (Type or Print): MARY EMMA BRYSON

2. DATE OF DEATH: July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 341 Dolphin Street
C. Length of stay in Baltimore: 52 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 341 Dolphin Street 11-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	Jan. 30, 1897	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Mary Boyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. Curland Johnson	Dolphin Street 341

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 12 days

DUE TO

(B) HYPERTENSIVE CARDIO-VASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(C) — INTERVAL BETWEEN ONSET AND DEATH: 1

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/17, 1949 *to* 7/6, 1949 *that I last saw the deceased alive on* 7/2, 1949 *and that death occurred at* 4:29 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Paulon Grant M. D.	601 N. Carrollton	7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/11/49	Mt. Auburn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave.

VS 150

93D

G76082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76082 Registered No.

1. NAME OF DECEASED (Type or Print): Christina Warrington
2. DATE OF DEATH: July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3315 Sinn St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25 06
D. STREET ADDRESS (If rural, give location): 3315 Sinn St Fairfield

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	C.	Widow	June 1, 1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Charles County Md.	

13. FATHER'S NAME: George Young
14. MOTHER'S MAIDEN NAME: Adline Jennifer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Florence Middleton	3315 Sinn St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio Vasc. Dis. — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO

(B)
DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1947 *to* July, 1949 *that I last saw the deceased alive on* 3 July 1949, *and that death occurred at* 9 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	1215 Mad Ave	7 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 8/49	Mt Calvary Cem.	Balto County Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	Mrs. Gott & Ellis Dy	937 1129 N. Carrollton

VS 150

G76083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76083

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DORA BASS

2. DATE OF DEATH 7-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 524 Queensberry Ave

c. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-17
D. STREET ADDRESS (If rural, give location) 524 Queensberry Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow		80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Not Known

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Tillie Bass ADDRESS 524 Queensberry

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) about 5 yr.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/2/44 19__, to July 8, 19 49, that I last saw the deceased alive on July 7, 19 49, and that death occurred at 3:40 P.M., from the causes and on the date stated above.

23A. SIGNATURE Nathan H. Shpritz M. D. | 23B. ADDRESS 1810 Eutaw Pl. | 23C. DATE SIGNED 7/9/49.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7-8-49 | 24C. NAME OF CEMETERY OR CREMATORY Hebrew Mt. Carmel | 24D. LOCATION (City, town, or county) Balto (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 8 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Jack Lewis Inc | ADDRESS 2100 Eutaw Pl

VS 150

93D

G76084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33 1

G76084 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Anna Krieger

2. DATE OF DEATH 7-7-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto Gen Hosp.

c. Length of stay in Baltimore Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-13

D. STREET ADDRESS (If rural, give location) 2814 Cold Spring Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	M		66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		New York	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Taylor	Shanda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Henry Krieger	2814 Cold Spring Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Cerebrovascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)

DUE TO

(C) — at least

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Adenocarcinoma of the fundus of the uterus — 6 mos.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-6 1949, *to* 7-7, 1949, *that I last saw the deceased alive on* 7-7 1949, *and that death occurred at* 9 a.m. P m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
W Arun Gd Davis	West Balto Gen Hosp	7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-8-49	United Hebrew	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, MD	Jack Lewis Inc	2100 Eutaw Pl.

VS 150

48B.

676085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 676085

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs Minnie Krieger Kleinhard

2. DATE OF DEATH 7-7-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Levindale

c. Length of stay in Baltimore 29 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-17
D. STREET ADDRESS (If rural, give location) Levindale

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH
9. AGE (In years last birthday) 82 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Harry
14. MOTHER'S MAIDEN NAME Nora

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Henry Krieger 209 W 99 St NYC ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C) Pyelonephritis. — 3 weeks
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic cardio-vascul. disease — Sev. years

19A. DATE OF OPERATION.
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 16, 1948 to 7-7-, 1949, that I last saw the deceased alive on 7-7, 1949, and that death occurred at 12.50 p m., from the causes and on the date stated above.

23A. SIGNATURE Jerome J. Blumberg M. D.
23B. ADDRESS Levindale Home
23C. DATE SIGNED 7-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-8-49
24C. NAME OF CEMETERY OR CREMATORY Beth Tfiloh
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 8 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eutaw Pl

VS 150

937

76086

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76086

Registered No.

1. NAME OF DECEASED (Type or Print) Raymond E. Carroll, Sr. 401-1

2. DATE OF DEATH July 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto Gen Hosp

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md. B. COUNTY Wash.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hagerstown
D. STREET ADDRESS (If rural, give location) 139 North Potomac St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
M	W	M	1915	33				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Hagerstown Md.	US

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO Subacute Bacterial Endocarditis of the aortic valve — INTERVAL BETWEEN ONSET AND DEATH: 2-3 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Rheumatic Heart Disease (Mitral Stenosis Mild Aortic Stenosis, Severe) — 20 years

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-5-49, 19__, *to* 7-7-49, 19__, *that I last saw the deceased alive on* 7-7, 1949, *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marvin W. Davis M. D.	West Balto Gen Hosp	7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Rose Hill	Hagerstown

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, MD	Fred. Kriss	Hagerstown Md.

VS 150

Correct age is important. Typewriter preferred.

76087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

'81

G76087

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES J. PURSER

2. DATE OF DEATH July 7, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3112 GLENMORE AVE

3c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 3112 Glenmore Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md. 27-05
D. STREET ADDRESS (If rural, give location) 3112 Glenmore Ave

5. SEX M.

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Mar 17, 1880

9. AGE (In years last birthday) 69 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN. SALES.

10B. KIND OF BUSINESS OR INDUSTRY Wholesale Shoes.

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Purser

14. MOTHER'S MAIDEN NAME Mary Dausch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —

16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-05-1049A

17. INFORMANT ADDRESS Mrs Elizabeth Purser 3112 Glenmore Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Urinary Bladder — INTERVAL BETWEEN ONSET AND DEATH: 9 Months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1942 *to* 7-7-, 1949, *that I last saw the deceased alive on* 7-5-, 1949, *and that death occurred at* 3P m., *from the causes and on the date stated above.*

23A. SIGNATURE C. W. Peake M. D.

23B. ADDRESS 4508 Harford Road

23C. DATE SIGNED 7-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 9, 1949

24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery

24D. LOCATION (City, town, or county) (State) Taylor Ave Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 8 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Howard N. Blight Jr. ADDRESS 6009 Harford Rd.

VS 150

52B

BIRTH NO. 76088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76088

1. NAME OF DECEASED (Type or Print): George Ruppert

2. DATE OF DEATH: July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ~~INSTITUTION~~ St. Joseph's
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Rural (Westminster)
D. STREET ADDRESS (If rural, give location): 243 E. Main St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	Single	Mar. 11 1866	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Westminster	U.S.

13. FATHER'S NAME: [illegible]

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH. (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Arteriosclerosis, Generalized, Senile

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-22-49	O.D. Extra. cap Cataract extraction	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 21, 1949 *to* July 8, 1949, *that I last saw the deceased alive on* July 8, 1949 *and that death occurred at* 5:00 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. K. Kaan M. D.	1400 N. Caroline St.	July 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 11-49	St Johns Cemetery	Westminster Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 8 1949	Huntington Williams, M.D.	H Bankard, Son Westminster Md

VS 150

838

G76089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76089

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Queen Victoria Tiedemann

2. DATE OF DEATH July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Md. Gen'l Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland

c. Length of stay in Baltimore 57 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-05
D. STREET ADDRESS (If rural, give location) 2519 Christian Street #23

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	Feb 5, 1892	57 57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	USA

13. FATHER'S NAME: BRUCE ARMSWORTHY

14. MOTHER'S MAIDEN NAME: NETTIE GOLDSBOROUGH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Lewis C. Tiedemann (husband) as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thromboses — INTERVAL BETWEEN ONSET AND DEATH: approximately 1 week

DUE TO

(B) Hypertensive arteriosclerotic cardio vascular disease — Unknown

DUE TO

(C) Diabetes mellitus — 13 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Phlebothromboses, chronic passive congest. — several weeks

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-1, 1949 *to* 7-6, 1949 *that I last saw the deceased alive on* 7-6, 1949 *and that death occurred at* 7 55 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marguerite Louisa Candler M. D.	Maryland General Hosp.	July 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	July 13 '49	LOUDON PARK	BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 8 1949		HARRY H WITZKE - 4101 EDMONDSON Ave

VS 150

61

G76090

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1949 G76090
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George T. Stinchcomb Sr.

2. DATE OF DEATH 7/6/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-43
D. STREET ADDRESS (If rural, give location) 2826 Maisel St

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2826 Maisel St.

3c. Length of stay in Baltimore 20 yrs. Yrs. Mos. Days

5. SEX M.
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Jan. 1, 1870
9. AGE (In years last birthday) 79 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY United Distillery
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Nelson Stinchcomb
14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-09-7184
17. INFORMANT Geo. T. Stinchcomb Jr. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Metastatic Carcinoma Prostate Gland ?
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertrophic arthritis, extensive — unknown

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 2, 1948, *to* July 6, 1949, *that I last saw the deceased alive on* [illegible], 19[illegible], *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE Nathan Raevsin M. D.
23B. ADDRESS 206 S. Gilmor St.
23C. DATE SIGNED 7-8.49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/8/49
24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet
24D. LOCATION (City, town, or county) (State) 2930 Frederick Rd. Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 8 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Harry H. Kirkpatrick
ADDRESS 1401 Edmondson Ave.

VS 150

51B

G76091 331 ✓ G76091

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 76091

1. NAME OF DECEASED (Type or Print): Deborah E. Hensler

2. DATE OF DEATH: July 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 413 N. Loudon Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-07
D. STREET ADDRESS (If rural, give location): 413 N. Loudon Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	5-9-1869	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Killmond
14. MOTHER'S MAIDEN NAME: Laura Wills
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT (son) ADDRESS: Geo.J.Hensler-413 N.Loudon Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis-hypertension — 8 yrs.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-26-, 1949 *to* 7-5-, 1949 *that I last saw the deceased alive on* 7-5-, 1949, *and that death occurred at* 11 A. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Thomas U. Todd M. D.
23B. ADDRESS: 2108 St. Paul St
23C. DATE SIGNED: 7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-9-49	New Cathedral	Baltol, Md.

DATE RECEIVED BY LOCAL REGISTRAR: 7-8-49
REGISTRAR'S SIGNATURE: Huntington Williams, M.D
25. FUNERAL DIRECTOR ADDRESS: Harry H.Witzke-4101 Edmondson Ave.

VS 150

83-2

98

6092 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76092 Registered No. 3698

1. NAME OF DECEASED (Type or Print) Louis BAKER

2. DATE OF DEATH 7-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 625 Mosher St.

C. Length of stay in Baltimore 2 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 625 W. Mosher St 14-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	widower	8-?-1851	98	11	?

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Baker

14. MOTHER'S MAIDEN NAME Mae Carter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. none

17. INFORMANT Mrs. Bessie Baker ADDRESS 625 Mosher St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

(B) Arterio Sclerosis — unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-1-, 1947 *to* 7-7-, 1949 *that I last saw the deceased alive on* 7-6-, 1949, *and that death occurred at* 7:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank A. Saunders M. D.	1029 N. Stricker St.	7-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/149	Mt Auburn	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	Geo. B. Kelso	1303 Eastern Ave

VS 150

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76093 ✓ 019.2 G76093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John Henry Sweeper

2. DATE OF DEATH July 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital
Wyman Park Drive & 31st Street

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 428 Carrollton Avenue 1802

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Married	Mar. 12, 1920	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
2nd cook	seafarer	South Carolina	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Sweeper	Mary Lee Sumpter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	249-30-3062	Records--US Marine Hospital, Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Miliary tuberculosis — Interval between onset and death: Unknown
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* June 14, 1949, *to* July 2, 1949, *that I last saw the deceased alive on* July 2, 1949, *and that death occurred at* 2:00p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M. D.	US Marine Hospital, Baltimore	7-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/8/49	Charleston S.C.	Charleston S.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	Mrs Kate R. Williams	322 N. Schroeder St

VS 150

13B

G76094

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43

Registered No. G76094

1. NAME OF DECEASED (Type or Print) Ada Minor.

2. DATE OF DEATH July 6, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 834 N. Carey St.,

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 834 N. Carey St.,

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 834 N. Carey St. 16-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	C	married	March 2, 1903	46.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife.		South Boston, Va..	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Fields.	Katie Palmer.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		Harry W. Minor.	834 N. Carey St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2-3 hrs

DUE TO

(B) Hypertensive Arter-Ver Dis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 29, 1949, to July 6, 1949, *that I last saw the deceased alive on* July 6, 1949, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jno McDonald M. D.	844 N Carey St	7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-10-49	Mt. Auburn Cem	Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	Wm Luther R. Williams	922 N. Schroeder St

VS 150

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 1949 G76095

Registered No.

1. NAME OF DECEASED (Type or Print) ROY ARNOLD WOOD — N-874-V

2. DATE OF DEATH July 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland Penitentiary

c. Length of stay in Baltimore — Yrs. 2 — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Whitehall
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
male	white	Single	Nov. 9-1922	27				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Masonry	Block Layer	Baltimore	U S

13. FATHER'S NAME: Abraham H Wood

14. MOTHER'S MAIDEN NAME: Eliza F Hash

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Abraham H. Wood — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage

DUE TO incised wound of the neck with

(B) severed right internal jugular vein

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) penitentiary

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Maryland Penitentiary, Eager & Forest St

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY July 7, 1949, 10.30 P.M.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Sharp instrument

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED July 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 10-1949	Bethel	Hartford Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 8 1949

REGISTRAR'S SIGNATURE: [signature] Washington Williams, M.D.

25. FUNERAL DIRECTOR: Howard A. Warfield — ADDRESS: 1641 Eutaw Place

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CORRECT AGE IS especially important

G76096

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 43

Registered No. G76096

1. NAME OF DECEASED (Type or Print) W. Francis Reisner RIESNER

2. DATE OF DEATH 7/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 29-4
D. STREET ADDRESS (If rural, give location) 423 Chapel Gate Rd.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	1/10/1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MAITRE'S	Belvedere Hotel	Maryland	U.S.A.

13. FATHER'S NAME Christopher Reisner

14. MOTHER'S MAIDEN NAME Theresa Zorn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		216-09-6928	REV. ALBERT J RIESNER	423 N CHAPEL GATE RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Central hemorrhage, Left — approx 2 wks.

DUE TO

(C) Hypertensive CVD — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/5, 1949, *to* 7/7, 1949 *that I last saw the deceased alive on* 7/7, 1949 *and that death occurred at* 12:50 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert L. Kerikas M. D.	St. Agnes Hospital	7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	JULY 11 1949	HOLY REDEEMER	4430 BELAIR RD MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	Duffel Bros	7110 BELAIR RD.

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937

Dr. J. A. Schmunck 1337 S. Charles St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Vol. 1 G76097 Registered No. G76097

G76097 BIRTH NO.

1. NAME OF DECEASED (Type or Print) Henry B. Strotman

2. DATE OF DEATH 7/6/49 1:40 a.m.

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1731 Belt St. 24-04

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1731 Belt St.

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	10/17/1886	62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Fairfield Ship Yard	Balto. Md.	

13. FATHER'S NAME Henry Strotman

14. MOTHER'S MAIDEN NAME Elizabeth Vondrasmohlan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W. W. I	213-01-9536	Mary Strotman	1731 Belt St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Insufficiency
DUE TO
(B) Arteriosclerosis &
DUE TO
(C) Myocarditis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1 1949 to July 5 1949, that I last saw the deceased alive on July 5 1949, and that death occurred at 1:40 m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Schmunck M. D.	1337 S. Charles St.	7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/9/49	Balto. National	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	Wm Cook Inc.	127 St. Paul St.

VS 150

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G76098

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76098

1. NAME OF DECEASED (Type or Print) Barbara Elaine Parker

2. DATE OF DEATH 7-8-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital Baltimore-18, Md.

c. Length of stay in Baltimore 0 Yrs. 0 Mos. 18 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cambridge
D. STREET ADDRESS (If rural, give location) 124 Glasgow St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hours Hours	If Under 24 Hours Min.
F	W	Infant	5-21-1949	0	1	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	U. S. A. Cambridge, Md.	U. S. A.

13. FATHER'S NAME Mr. Robert Edgar Parker

14. MOTHER'S MAIDEN NAME Florence Ruth Pete

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	none	Parents	Cambridge Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cystic hygroma of neck — INTERVAL BETWEEN ONSET AND DEATH: 1 mo. 8 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) hygroma

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-21, 1949 *to* 7-8, 1949 *that I last saw the deceased alive on* 7-8, 1949, *and that death occurred at* 5:57 A *m., from the causes and on the date stated above.*

23A. SIGNATURE, M. D.	23B. ADDRESS	23C. DATE SIGNED
Alvin Bonzheaar	Mayor Memorial Hosp.	7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/8/49	?	Cambridge, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS INC.	North & Pa. Aves Balto. 17, Md.

VS 150

56E

676099

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

175 676099

Registered No.

1. NAME OF DECEASED (Type or Print) **Bertha Louise Mahling**

2. DATE OF DEATH **7-6-49**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **2791 ½ Alameda Blvd.**

C. Length of stay in Baltimore **Life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY **City**
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **2791½ Alameda Blvd.** 9-706

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	**White**	**Married**	**Feb. 16th., 1881**	**68**	**4 / 20**	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		**Baltimore, Maryland**	**U.S.A.**

13. FATHER'S NAME **August Happel**

14. MOTHER'S MAIDEN NAME **Bertha Henze**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		**219-01-2901 B.**		

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Bronchial Pneumonia* — INTERVAL BETWEEN ONSET AND DEATH: *24 hrs*

DUE TO

(B) *Carcinoma of Right Ovary* — *3 mo*

DUE TO

(C) *Hypertension, Arteriosclerosis* — *yrs*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from July 6, 1948, to July 6, 1949, that I last saw the deceased alive on July 5, 1949, and that death occurred at 6 a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. F. A. Stevens M. D.	*2818 Harford Rd*	*July 7 49*

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**7-8-49**	**Holy Redeemer Cemetery**	**Belair Rd. Balto: Md.**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JUL 8 1949	*Custis for Williams, M.D.*	**George J. Ruth, Inc. 1735 Harford Avenue**

VS 150

49a

G76100

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76100

Registered No.

1. NAME OF DECEASED (Type or Print) William E. Cain

2. DATE OF DEATH 7-7-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1009 Valley St.

c. Length of stay in Baltimore 78 Yrs. 7 Mos. 26 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 1009 Valley St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	11-13-1870	78	7 / 26	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Telesk. Retired	Balto City Water Bu	Baltimore Md.	U.S.A.

13. FATHER'S NAME William E. Cain

14. MOTHER'S MAIDEN NAME Catherine O'Brien

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no.	None	Miss Ellen G. Cain	1009 Valley St

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 Mo.

DUE TO

(B) Cardio-Vascular-Renal Disease — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 5, 1949 *to* July 7, 1949, *that I last saw the deceased alive on* 6 July, 1949 *and that death occurred at* 1:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. Silverfarb M.D.	714 E. Preston St.	7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-9-49	Parkwood Cemetery	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	Elmer W. Conklin	924 E. Eager St

VS 150

1310

G76101

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76101

1. NAME OF DECEASED (Type or Print) Harry G. Smith

2. DATE OF DEATH July 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3114 Baker St.,

c. Length of stay in Baltimore 63 -- (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3114 Baker St.,

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	May 25, 1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Floor Manager	Barney's Bargain House	Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edwin Smith	Mary Oliver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		216-09-2177	Mrs. Pearle M. Smith	3114 Baker St.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary thrombosis	6 hours
DUE TO		
ANTECEDENT CAUSES (B)	Arteriosclerosis	?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Diabetes mellitus	1 year

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1949 *to* 7/7, 1949 *that I last saw the deceased alive on* 4/3, 1949 *and that death occurred at* 8 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Alan Bernstein M. D.	1109 N Calvert St	7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-9-1949	Baltimore	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	G. Howard Strong	3207 W. North Ave.,

VS 150

61

G76102

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 re 1

G76102

Registered No.

1. NAME OF DECEASED (Type or Print) CHARLES WILLIAM MILLER

2. DATE OF DEATH July 6, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2120 Greenmount Ave. 12-04

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH June 17,1893

9. AGE (In years last birthday) 56 55

If Under 1 Year: Months / Days

If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Miller

14. MOTHER'S MAIDEN NAME Virginia May Wiseman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes

(If yes, give war or dates of service) WWI

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT Records- US Marine Hospital, Balto, Md. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) 1- Coronary sclerosis with thrombosis and myocardial infarction — Interval between onset and death: Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) 2- Rheumatoid arthritis — Unknown

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 6, 1949 *to* July 6, 1949 *that I last saw the deceased alive on* July 6, 1949, *and that death occurred at* 8:15P m., *from the causes and on the date stated above.*

23A. SIGNATURE John L. Wilson M. D.

23B. ADDRESS US Marine Hospital Balto, Md.

23C. DATE SIGNED 7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify) -B-

24B. DATE 7-11-49.

24C. NAME OF CEMETERY OR CREMATORY BALTO. NAT'L.

24D. LOCATION (City, town, or county) (State) CITY

DATE RECEIVED BY LOCAL REGISTRAR JUL 8 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR WIEDEFELD & SON ADDRESS GREENMOUNT AVE & 22ND 94a

VS 150

G76103 ✓ ✓ 76 G76103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49. 13877 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Lange

2. DATE OF DEATH: July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 32
D. STREET ADDRESS (If rural, give location): 322 Overbrook Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	July 8, 1949			30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Norman Lange
14. MOTHER'S MAIDEN NAME: Winifred Schwartz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: 332 Overbrook Rd ADDRESS 32

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 30 min.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A), STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm Bailey M. D.
23B. ADDRESS: Mercy
23C. DATE SIGNED: 7-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B.	7-8-49	St. Peters	City

DATE RECEIVED BY LOCAL REGISTRAR: JUL 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wiedefeld & Son ADDRESS: Greenmount Ave & 22nd 159

VS 150

G76104

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 931.0

Registered No. G76104

1. NAME OF DECEASED (Type or Print) Walter Johnson — N-981.0 — 2. DATE OF DEATH 7-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1002 Linden Ave. 11-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Married	Sept 10 1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer — 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Prospect Va. — 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Daniel Johnson — 14. MOTHER'S MAIDEN NAME Liza

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. 217169294 — 17. INFORMANT Hospital Record. — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Heat stroke
DUE TO

ANTECEDENT CAUSES

(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	No	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
No m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-6 19 49, *to* 7-7, 19 49, *that I last saw the deceased alive on* 7-7, 19 49, *and that death occurred at* 7 00 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. E. Brady M. D.	Provident Hospital	7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 11, 1949	Mt. Auburn	Westport, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	Charles H. Alexander	1200 McCulloh St Baltimore, Md.

VS 150

191

376105
AB-129346
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 376105

1. NAME OF DECEASED (Type or Print) John McCotter — 541.1

2. DATE OF DEATH: July 6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 944 S. East Ave. 7b-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 1 day: Hours	Min.
M	W	Married	Jan. 31- 1874	75				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		N.C.	

13. FATHER'S NAME: (D

14. MOTHER'S MAIDEN NAME: (D

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT'S NAME AND ADDRESS: Baltimore City Hospitals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Questionable Heat Stroke
DUE TO Aspiration pneumonia
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-18-49	Perforated duodenal ulcer	YES XXX NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-1- , 1949 *to* 7-6- , 1949 *that I last saw the deceased alive on* 7-6- , 1949 *and that death occurred at* 3.25PM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T. S. Rogers M. D.	Baltimore City Hospitals	7-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/9/49	Schwartz's Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 8 1949	Tuntington Williams, M.D.	Lilly & Zeiler, Inc. 403 S. Wolfe St.

VS 150

93D

G76106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

143

G76106

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) John Hythe

2. DATE OF DEATH 7/6/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 828 N. Carey St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md.

D. STREET ADDRESS (If rural, give location) 828 N. Carey St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	M	May 20, 1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME James Hythe

14. MOTHER'S MAIDEN NAME Lucy Gray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		?

17. INFORMANT Ella Hythe ADDRESS 828 N. Carey St. Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 6 Mo.

DUE TO

(B) Atterio-Scl.hyp.-card.Vas-Disease ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 22 1949 *to* July 6 1949, *that I last saw the deceased alive on* July 6 1949, *and that death occurred at* 2 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. McDonald M. D.	844 N Carey Balto. Md	7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/9/49	Arbutus Memorial Pk, Inc	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Turnington Williams, M.D.	Geo. G. Kelson	1303 Presstman St.

VS 150

93D

G76107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

490

Registered No. G76107

BIRTH NO. B.C. H-01140

1. NAME OF DECEASED (Type or Print) Martha L. Willis

2. DATE OF DEATH 7/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
St Agnes Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, 20
D. STREET ADDRESS (If rural, give location) 1711 Upton St. 25-43

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	single	6/20/44	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Robert Lee Willis

14. MOTHER'S MAIDEN NAME Evelyn C.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) OVERWHELMING TOXEMIA

DUE TO

(B) ACUTE UPPER RESPIRATORY INFECTION

DUE TO

(C) BILATERAL PNEUMONIA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/6, 1949 *to* 7/7, 1949 *that I last saw the deceased alive on* 7/7, 1949 *and that death occurred at* 11:10 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE John H. Shaw M. D.

23B. ADDRESS St. Agnes Hosp.

23C. DATE SIGNED 7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7-9-49

24C. NAME OF CEMETERY OR CREMATORY Loudon Park

24D. LOCATION (City, town, or county) (State) Frederick Rd ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR JUL 8 1949

REGISTRAR'S SIGNATURE Contingent for Williams, M.D.

25. FUNERAL DIRECTOR Edward Fowlson

VS 150

108

G76108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ X 744.0

Registered No. G76108

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Homer C. Osebaugh

2. DATE OF DEATH JUL 8 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
STATE Va. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Newport News

D. STREET ADDRESS (If rural, give location) 315 27th St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	6-5-88	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Metal Business

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Osebaugh

14. MOTHER'S MAIDEN NAME Hattie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myasthenia Gravis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-6 1949 *to* 7-8 1949, *that I last saw the deceased alive on* 7-8 1949, *and that death occurred at* 5:50 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Robert C. Hantzmann M. D. — 23B. ADDRESS JOHNS HOPKINS HOSPITAL — 23C. DATE SIGNED 7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal — 24B. DATE 7/10/49 — 24C. NAME OF CEMETERY OR CREMATORY Greenlawn — 24D. LOCATION (City, town, or county) (State) Newport News Va.

DATE RECEIVED BY LOCAL REGISTRAR JUL 8 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR Wm Cook Inc. — ADDRESS

VS 150

156B

C76109
STATE FILE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59

Registered No. C76109

1. NAME OF DECEASED (Type or Print) Ruth E. Eckstorm

2. DATE OF DEATH 7-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Sq Hosp.

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 23-07
D. STREET ADDRESS (If rural, give location) 18 E. Hamburg

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
F	W	MARRIED	12/25/1902	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY H W

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Sam Smith

14. MOTHER'S MAIDEN NAME Florence Gallino

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Husband George W. Eckstorm ADDRESS 18 E. Hamburg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Chronic nephritis — Yes
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-27 1949 *to* 7-6, 1949 *that I last saw the deceased alive on* 7-6, 1949, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE T. J. Laham M. D. — 23B. ADDRESS Franklin Sq Hosp — 23C. DATE SIGNED 7-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE 7/9/49 — 24C. NAME OF CEMETERY OR CREMATORY Glen Haven — 24D. LOCATION (City, town, or county) (State) Annapolis Blvd

DATE RECEIVED BY LOCAL REGISTRAR JUL 8 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR John F. Denny Inc — ADDRESS 714 Light St.

VS 150

1316

G76110

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76110

Registered No.

1. NAME OF DECEASED (Type or Print) Elizabeth A. Schneider

2. DATE OF DEATH 7/6/49 8:25 P.M.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3809 Ridgecroft Rd

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto 27-01
D. STREET ADDRESS (If rural, give location) 3809 Ridgecroft Rd

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 12/30/1890
9. AGE (In years last Birthday) 58
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Anton Kemmerzell
14. MOTHER'S MAIDEN NAME Hermina Kahler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Harry W. Schneider ADDRESS 3809 Ridgecroft Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Stomach
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 5/14/49
19B. MAJOR FINDINGS OF OPERATION Inoperable Carcinoma of Stomach
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 5, 1949 *to* July 6, 1949 *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* 8:25 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Charles E. Carr M.D.
23B. ADDRESS 6007 York Road
23C. DATE SIGNED 7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/9/49
24C. NAME OF CEMETERY OR CREMATORY Parkwood
24D. LOCATION (City, town, or county) (State) Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 8 1949
REGISTRAR'S SIGNATURE Livingston Williams M.D.
25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1217 St. Paul St.

VS 150

46 B

76111
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT 331 G76111
CERTIFICATE OF DEATH
Registered No.

1. NAME OF DECEASED (Type or Print) Dr. Charles C. Cook
2. DATE OF DEATH 7-6-49

3. PLACE OF DEATH: Baltimore City, Maryland
3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
3c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1239 Druid Hill Avenue 11-04

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Dec 18-1864
9. AGE (In years last birthday) 84
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician & Pharmacist
10B. KIND OF BUSINESS OR INDUSTRY self
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Christian Cook
14. MOTHER'S MAIDEN NAME Margaret ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Robert J. Young, 501 Sanford Place ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebro-Vascular Accident
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-6 19 49 *to* 7-6 19 49 *that I last saw the deceased alive on* 7-4 19 49 *and that death occurred at* 1520 *m., from the causes and on the date stated above.*

23A. SIGNATURE John A Hightower M.D.
23B. ADDRESS University Hosp.
23C. DATE SIGNED 7-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial
24B. DATE 7/9/49
24C. NAME OF CEMETERY OR CREMATORY Baltimore
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR JUL 8 1949
REGISTRAR'S SIGNATURE Temperance Williams, M.D.
25. FUNERAL DIRECTOR Wm. Cook, Inc., ADDRESS 1217 St. Paul Street

VS 150

83a

~~76112~~

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76112

1. NAME OF DECEASED (Type or Print): Diana Murray

2. DATE OF DEATH: July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1711 3E

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: N.C. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rocky Mount
D. STREET ADDRESS (If rural, give location): 1410 S. Franklin St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: 9-16-46
9. AGE (In years last birthday): 2 — If Under 1 Year: Months 10, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard Murray
14. MOTHER'S MAIDEN NAME: Dale Bridges

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease, cyanotic type.
DUE TO
(B) Aorta arising from R. ventricle. Interventricular septal defect. Pericardial and pleural effusions.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-8-, 1949 *to* 7-8-, 1949 *that I last saw the deceased alive on* 7-8-, 1949, *and that death occurred at* 7:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: William W. Mann M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 7/8/49
24C. NAME OF CEMETERY OR CREMATORY: Pine View
24D. LOCATION (City, town or county) (State): Rocky Mount N.C.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 8 1949
REGISTRAR'S SIGNATURE: Penelope for Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook Inc. ADDRESS: 1217 St Paul St

VS 150

157E

G76113

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76113

1. NAME OF DECEASED (Type or Print) Carrie R. Bayly

2. DATE OF DEATH July 7-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2917 Parkwood Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 78 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-04

D. STREET ADDRESS (If rural, give location) 2917 Parkwood Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	White	Single	Feb. 1871	78	5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	At Home	Baltimore	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thos. R. Bayly	Rosalia Busby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	—	Thos. R. Bayly. 2917 Parkwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 7/3/49

DUE TO

(B) Chr. Myocarditis — 1941

DUE TO

(C) Arteriosclerosis — 1941

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct. 14 - 1943 *to* July 7, 1949 *that I last saw the deceased alive on* July 6, 1949 *and that death occurred at* 7:15 *a. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul Brown M. D.	1663 W. North Ave.	7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/9/49	New Cathedral Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Courtesy for Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

93D

G76117

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

57-5

G76114

Registered No.

1. NAME OF DECEASED (Type or Print): Levy, Rae (Goodman)

2. DATE OF DEATH: July 8, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland Sinai Hospital

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 2 — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Indiana
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Indianapolis
D. STREET ADDRESS (If rural, give location): 5360 N. Central

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	M	9/13/94	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Virginia	U.S.A.

13. FATHER'S NAME: FRANCIS GOODMAN

14. MOTHER'S MAIDEN NAME: ROSE DAVIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolism
DUE TO
(B) Rheumatic Heart Disease
DUE TO
(C) Intestinal Obstruction

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 5, 1949	Closed colostomy	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from July 1, 1949, to July 8, 1949, that I last saw the deceased alive on July 8, 1949, and that death occurred at 11:15 A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
P. Leonard Hesse M. D.	Sinai Hospital	July 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Indianapolis Ind	July 8/49		Indianapolis Ind

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 8 1949	Huntington Williams, M.D.	Nash Goodheim & Son

VS 150

122 B

G76115

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 G76115

Registered No.

1. NAME OF DECEASED (Type or Print) Mary Edith Cross

2. DATE OF DEATH July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Md. Gen'l Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

C. Length of stay in Baltimore 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 617 Dunbarton Avenue 9-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	single	Feb 20, 1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Teacher retired	Teaching	Maryland	U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT (sister) Harriet T. Cross ADDRESS (same as deceased)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

(B) Hypertensive arteriosclerotic cardiovascular disease — Un Known

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 5, 1949 *to* July 6, 1949 *that I last saw the deceased alive on* July 6, 1949, *and that death occurred at* 6.30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marguerite Louise Cadle M. D.	Maryland General Hospital	July 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 8, 1949	Moreland Memorial Park	Parkville, Balto Co, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	JOHN BURNS' SONS	Towson, Md.

VS 150

931

G76116

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76116

1. NAME OF DECEASED (Type or Print): CHARLES EBERT

2. DATE OF DEATH: JULY 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 325 S. PULASKI ST.
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 20-03
D. STREET ADDRESS (If rural, give location): 325 S. PULASKI ST.

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: AUG. 18, 1878
9. AGE (In years last birthday): 70 71 (If under 1 Year: Months 2, Days 18; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CANDY MAKER
10B. KIND OF BUSINESS OR INDUSTRY: CANDY MFG.
11. BIRTHPLACE (State or foreign country): BALTO., MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: AUGUST EBERT
14. MOTHER'S MAIDEN NAME: LOUISE SCHNELLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: 216-05-7242
17. INFORMANT: WILLIAM P. EBERT ADDRESS: 325 S. PULASKI ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Chronic Nephritis — 2 year
DUE TO
(C) Prostatic Obstruction — 3 year

ANTECEDENT CAUSES
DISEASES OR CONDITIONS. IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Aug 1946
19B. MAJOR FINDINGS OF OPERATION: Granulation tissue of prostatic removed opening
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 12, 1947 *to* July 6, 1949, *that I last saw the deceased alive on* July 6, 1949, *and that death occurred at* 9:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: John O. Ulrich, Jr. M. D.
23B. ADDRESS: 1227 Wash. Blvd
23C. DATE SIGNED: 7-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 7-9-49
24C. NAME OF CEMETERY OR CREMATORY: LOUDON PARK
24D. LOCATION (City, town, or county) (State): BALTIMORE, MD.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 9 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: GEO. L. SCHWAB ADDRESS: 2101 FREDERICK AVE

VS 150

1310

G76117

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

'49 Registered No. G76117

1. NAME OF DECEASED (Type or Print) **Walter E. Overstreet**

2. DATE OF DEATH **July 8, 1949**

3. PLACE OF DEATH: A. Baltimore City, Maryland **Baltimore, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **33 E. Mt. Vernon Place**

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **33 E. Mt. Vernon Place** 11-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Married	Oct. 24, 1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist	unemployed	Virginia	

13. FATHER'S NAME **(Unknown) Overstreet**

14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no	

17. INFORMANT **Mrs. Marjorie Overstreet,** ADDRESS **33 E. Mt. Vernon**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cancer of tongue with Generalized Metastases** — INTERVAL BETWEEN ONSET AND DEATH: **6 yrs.**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1943, 19__, *to* 7-8-49, 19__, *that I last saw the deceased alive on* 7-1-49, 19__, *and that death occurred at* 7 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. Eugene Covington M.D. M. D.	828 Park ave. Baltimore	7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/11/49	Moreland Park Cemetery	Parkville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9 - 1949	Huntington Williams, M.D.	Wm. Cook, Inc.,	1217 St. Paul Street

VS 150

45B

G76118 ✓X 9.4.3 G76118

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

N-9-V

1. NAME OF DECEASED (Type or Print) LEO W. KAROPCHINSKY

2. DATE OF DEATH July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Co. Lutherville
D. STREET ADDRESS (If rural, give location) 2402 Smith Avenue

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Married	9/20/1919	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinest	Elevator Eng.	Balto md.	-

13. FATHER'S NAME: Peter Karopchinsky

14. MOTHER'S MAIDEN NAME: Mary Vonszeska

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Yes	W. W. #2		Jeannette Karopchinsky 2402 Smith Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Electrocution — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	building	elevator at 606 S. Broadway 23

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 6, 1949 1.15 p. m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Came in contact with live wire while repairing elevator

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
William J. McCafferty M.D.		July 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	7/11/49	U. S. National	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9 - 1949	Huntington Williams, M.D.	Wm Cook Inc.	127 St. Paul St.

Correct age is especially important. Typewriter, please.

VS 151

193 ✓

76119 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 G76119 Registered No.

1. NAME OF DECEASED (Type or Print) Joseph GUDAITIS

2. DATE OF DEATH July 6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 821 N. Port St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 60y Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 821 N. Port St 7-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	?	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Lith.	?

13. FATHER'S NAME Joseph Gudaitis

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	220-07-1413	Margaret Gudaitis	821 N. Port St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HYPERTENSIVE C.V. DISEASE — 3 yrs.
DUE TO
(B)
DUE TO
(C) ARTERIOSCLEROSIS-General — 5 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan., 1945 *to* 7/6/, 1949, *that I last saw the deceased alive on* 7/6/, 1949, *and that death occurred at* 5:20 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benj. B. Moses M. D.	448 N. Longwood	7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	July 9-1949	Holy Redeemer Cem.	Belair Rd. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9 - 1949	Huntington Williams, M.D.	Joseph Kaunskas Inc	602 Wash.

VS 150

937 Bell

AB-127722
G76120

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76120

1. NAME OF DECEASED (Type or Print) John Ottinger

2. DATE OF DEATH July 7-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore 12yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4606 Charleston St.

5. SEX M
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Feb. 15-1876
9. AGE (In years last birthday) 73 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Daniel Ottinger
14. MOTHER'S MAIDEN NAME Elizabeth Bouier
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Baltimore City Hospitals Records- ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Terminal Pneumonia
DUE TO
(B) Carcinoma of Larynx
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 3-25-1949
19B. MAJOR FINDINGS OF OPERATION Carcinoma of Larynx
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-22- , 1949, *to* 7-7- , 1949, *that I last saw the deceased alive on* 7-7- 1949, *and that death occurred at* 3 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE C. S. Rogers M. D.
23B. ADDRESS Baltimore City Hospitals
23C. DATE SIGNED 7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify) B
24B. DATE 7-9-49
24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet
24D. LOCATION (City, town, or county) (State) Jersey, Md
25. FUNERAL DIRECTOR ADDRESS James L. McCurdy 130 E. Lanvale 47a

DATE RECEIVED BY LOCAL REGISTRAR JUL 9 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.

VS 150

CERTIFICATE CORRECTED 7-27-49 ✓

676121 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 676121

1. NAME OF DECEASED (Type or Print): MRS. HYLA McCOY

2. DATE OF DEATH: July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 215 TUSCANY ROAD 12 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	MARRIED	July 29, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		BALTIMORE, MD.	U.S.

13. FATHER'S NAME: JOHN TUNIS

14. MOTHER'S MAIDEN NAME: FANNIE HARMON.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	MR. John R McCoy	215 Tuscany Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 22 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 1949, to July 8, 1949, *that I last saw the deceased alive on* July 9, 1949, *and that death occurred at* 2:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John Allen Luttel, Jr. M.D.	Mercy Hospital	7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/11/49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9 - 1949	Huntington Williams, M.D.	F. H. Meare and Son	805 N. Calvert St (2)

VS 150

94a

G76122

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76122

1. NAME OF DECEASED (Type or Print): Lis, John.

2. DATE OF DEATH: 7 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSP. OF BALTO. INC.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 12 N. LAKEWOOD AVE Taneytown, Md.

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): ~~Married~~ Single
8. DATE OF BIRTH: January 28, 1898
9. AGE (In years last birthday): 51 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: SAM LIS
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 169-05-5299
17. INFORMANT: Walter A. Roder ADDRESS: 12 N. Lakewood Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) VENTRICULAR FIBRILLATION — INTERVAL BETWEEN ONSET AND DEATH: 5 MINUTES
DUE TO
(B) CARCINOMA OF LUNG — UNKNOWN
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 7 July 1949
19B. MAJOR FINDINGS OF OPERATION: CARCINOMA LUNG - RT LOWER LOBE
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): ACCIDENT
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5 July, 1949 *to* 7 July, 1949 *that I last saw the deceased alive on* 7 July, 19 49 *and that death occurred at* 3:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul C. Wintrop M. D.
23B. ADDRESS: SINAI HOSP. OF BALTO
23C. DATE SIGNED: 8 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/11/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): 4430 Belair Rd. Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUL 9 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 2601-3-5 E. Madison St.

VS 150

471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76123 Registered No.

1. NAME OF DECEASED (Type or Print) Annie Maly (Anna)

2. DATE OF DEATH 7/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4108 Glenarm Avenue
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore 60 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4108 Glenarm Avenue 27-34

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	July 8, 1860	89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Czechoslovakia	U.S.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Anton Maly - son	- above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
John R Davis, M.D.	X	7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/11/49	Oak Hill Cemetery	Horner's Lane, Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
APR 9 - 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 151

correct age is important, improper

930

G76124

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E983.5 G76124

Registered No.

1. NAME OF DECEASED (Type or Print): William Goddard N803.2

2. DATE OF DEATH: July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3424 Keswick Road 13-06

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Oct.2 1900
9. AGE (In years last birthday): 48
If under 1 year: Months / Days
If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: 219-10-8775
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: James E. Goddard
14. MOTHER'S MAIDEN NAME: Mc Carthy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): World War 1
16. SOCIAL SECURITY NO.: 219-10-8775
17. INFORMANT: Mrs. Mary E. Chalk ADDRESS: 3424 Keswick Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of skull
DUE TO Sub dural hemorrhage

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Stafford & Caton Sts
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 8, 1949 ? m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR?: Felled by fist, struck head on ground during an altercation)

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]
23C. DATE SIGNED: July 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 12.49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Natinal
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 9 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Grant H Seitz
ADDRESS: 814 W. 36th. S

VS 151

Correct age is expected. Typewriter preferred.

168

AB-88205
G76125

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4700 G76125 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Louis F. Dieterich

2. DATE OF DEATH July 8-1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1713 W.Lombard St.

19-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Single	Jan. 16- 1875	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland (Baltimore)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis P. Dieterich
14. MOTHER'S MAIDEN NAME: Elizabeth Boyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		no

17. INFORMANT: Records- ADDRESS: Baltimore City Hospitals 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Vascular Accident	
DUE TO		
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Arteriosclerotic Heart Disease	
DUE TO		
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-24- 1944 *to* 7-8- 1949 *that I last saw the deceased alive on* 7-8- 1949 *and that death occurred at* 6.05AM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. L. Rogers M. D.	Baltimore City Hospitals	7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/9/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9- 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

937

G76126

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-1 4 G76126

Registered No.

1. NAME OF DECEASED (Type or Print)	JENNIE McDUFFIE DASCH
2. DATE OF DEATH	July 7, 1949
3. PLACE OF DEATH: Baltimore City, Maryland	
a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	2954 Presstman St.
c. Length of stay in Baltimore (Yrs. Mos. Days)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Md.
B. COUNTY	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	2954 Presstman St. 12-07
5. SEX	female
6. COLOR OR RACE	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	married
8. DATE OF BIRTH	May 6, 1873
9. AGE (In years last birthday) If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.	76 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	housewife
10B. KIND OF BUSINESS OR INDUSTRY	home
11. BIRTHPLACE (State or foreign country)	Fayetteville, N. C.
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Thomas McDuffie
14. MOTHER'S MAIDEN NAME	Annie Ivey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	no
16. SOCIAL SECURITY NO.	no
17. INFORMANT / ADDRESS	Mr. W. Frank Dasch 2954 Presstman St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic valvular heart disease	
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* [illegible], 1940, *to* July 7th, 1949, *that I last saw the deceased alive on* July 6, 1949, *and that death occurred at* 6:00P m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS 537 Wildwood Pkwy.	23C. DATE SIGNED 7-8-49
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/11/49	24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
		24D. LOCATION (City, town, or county) (State) Balto., Md.
DATE RECEIVED BY LOCAL REGISTRAR JUL 9 - 1949	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR WM. J. TICKNER & SONS
		ADDRESS Balto., Md.

VS 150

Collect age is opening important

927

G76127

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No. G76127

1. NAME OF DECEASED (Type or Print) MARY AMELIA P. LEE

2. DATE OF DEATH July 8, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

3B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 208 Dolphin St.

3C. Length of stay in Baltimore — Yrs. Mos. Days

4D. STREET ADDRESS (If rural, give location) 208 Dolphin Street 17-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	colored	single	Aug. 23, 1901	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
domestic		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Lee	Agnes Pennington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mrs. Bettie Pennington	208 Dolphin St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐; *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
William J. McClafferty M.D.		July 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-11-49	Mt. Auburn Cem	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9 1949	Turning for Williams, M.D.	Mrs. Frances A. Hemsley	578 W. Biddle

Exact age if opening important. Typewriter, please.

931

BIRTH NO. 76128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76128

1. NAME OF DECEASED (Type or Print): ELAINE PITTS LOPEZ

2. DATE OF DEATH: 7-6-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 545 W. LAFAYETTE AVE.
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 17.
D. STREET ADDRESS (If rural, give location): 545 W. LAFAYETTE AVE. 17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
FEMALE	COLORED	MARRIED	8-9-1923	25	10	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	BALTIMORE, MARYLAND	

13. FATHER'S NAME: JAMES GOWENS

14. MOTHER'S MAIDEN NAME: BEATRICE PITTS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: EMORY LOPEZ — ADDRESS: 545 W. LAFAYETTE AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute Tubercular Pneumonia	2 wks.
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

CERTIFICATION APPROVED BY
For Robert B. McFadden
L. G. Merrill M. D.
CORO OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 6, 1949 *to* July 6, 1949 *that I last saw the deceased alive on* July 6th, 1949 *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert L. Jackson M. D.	600 N. Arlington Avenue	7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7-11-49	ARBUTUS MEM. PK.	BALTO. CO. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9 - 1949	Huntington Williams M.D.	Wm. B. Jackson	916 Penna. Ave.

VS 150

12B

G76129

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76129 Registered No.

1. NAME OF DECEASED (Type or Print) JENNINGS W. SATCHELL

2. DATE OF DEATH 7-6-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1528 DRUID HILL AVE

C. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 17

D. STREET ADDRESS (If rural, give location) 1528 DRUID HILL AVE. 14-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	COLORED	SINGLE	3-19-1918	31	4 / 27	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNEMPLOYED	—	BALTIMORE	

13. FATHER'S NAME PRESTON SATCHELL

14. MOTHER'S MAIDEN NAME REBECCA CUSTIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		REBECCA SATCHELL	1528 DRUID HILL AVE.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) pulmonary tuberculosis	18 days
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 29 June 1949, to 6 July, 1949 *that I last saw the deceased alive on* 6 July, 1949. *and that death occurred at* 4:45 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James D. Carr M. D.	1427 Madison Ave	7.8.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7-9-49.	MT. AUBURN	BALTIMORE MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9- 1949	Huntington Williams, MD	Wm. A. JACKSON	916 PENNA. AVE.

VS 150

13B

BIRTH NO. 76130

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47 0 0 ✓ Registered No. G76130

1. NAME OF DECEASED (Type or Print): ANNA K. DOELL
2. DATE OF DEATH: 7-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5440 Belair Rd Home Gardenville Convalescent
c. Length of stay in Baltimore: 75 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1469 Towson St. 24-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Widowed	3-15-1874	75	3			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Baltimore	U.S.A.

13. FATHER'S NAME: William Kummelmann
14. MOTHER'S MAIDEN NAME: Cora Neuslein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	217-10-2296	Lillian Ferguson	1469 Towson St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C) Cardio Vascular Renal Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Senile psychosis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 29, 1949 *to* July 6, 1949 *that I last saw the deceased alive on* July 6, 1949 *and that death occurred at* 10:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. V. Harbold M.D.	4706 Harford Road	July 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, county) (State)
Burial	7-11-49	Oaklawn	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9 - 1949	Huntington Williams, M.D.	Charles L. Hill	1301 E. Fort Ave

VS 150

131a

AB-129095
676131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 676131

1. NAME OF DECEASED (Type or Print): Lillie Mae Jenkins

2. DATE OF DEATH: July 5-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 565 Oxford St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Negro	Separated	Dec. 25- 1910	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Georgia	

13. FATHER'S NAME: (D

14. MOTHER'S MAIDEN NAME: (D

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT'S ADDRESS: Baltimore City Hospitals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculous Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 2mos.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Tuberculosis in Spleen, Peri-Aortic Lymph Nodes, Liver

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-19- , 1949, *to* 7-5- , 1949, *that I last saw the deceased alive on* 7-5- 1949, *and that death occurred at* 9.30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. Rozen M. D.	Baltimore City Hospitals	7-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	7/11/49	Mt. Calvary	A. A. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 1949	Huntington Williams, M.D.	W. Halstead	918 Druid Hill Ave.

14

76132
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76132

1. NAME OF DECEASED (Type or Print): John W. Preston
2. DATE OF DEATH: July 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 537 Moore St. 17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Widower	6/1/1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hod-Carrier		Harford Co. Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John W. Preston Sr.	Sallie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Robt. H. Preston — ADDRESS: 261 W. Preston St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic cardiovascular disease.	
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/9/49	Mt. Calvary	Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 8 - 1949	Registrar for Baltimore, Md.	D. Halstead	918 - 937 Cherrid Hill Ave.

VS 151-

Correct age is especially important. Physicians, please write plainly.

G76133

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76133

Registered No.

1. NAME OF DECEASED (Type or Print) Augusta Hamilton

2. DATE OF DEATH July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital.

c. Length of stay in Baltimore 39 ~~Yrs~~ Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Charles
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Waldorf
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Widowed.		65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
house wife	own home.	Maryland.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles W. Hett	Mary —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Hosp. Records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis (left) — INTERVAL BETWEEN ONSET AND DEATH: 36 hr.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Generalized Arteriosclerosis
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Thrombophlebitis rt leg - Chronic Cholecystitis & Cholylithisis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 19 49, *to* July 8, 19 49, *that I last saw the deceased alive on* July 8, 1949, *and that death occurred at* 5 45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H Patterson Macke M. D.	University Hospital	7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
	7/8/49		Waldorf Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9 - 1949	Hunter for Williams, M.D.	Hewitt & Bowen	Waldorf Md

VS 150

83B

G76134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76134

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM TOWNSON

2. DATE OF DEATH July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Crownsville
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	married		75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Litten Townson
14. MOTHER'S MAIDEN NAME: Adeline ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Irving Bennett — ADDRESS: Stockton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: William J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: July 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7/12/49		Stockton - Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Irving Bennett — ADDRESS: Stockton, Md.

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Correct age is supplying important [illegible]

.937

Dr. Grossfeld

BIRTH NO. 76135

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 no. 1

Registered No. 76135

1. NAME OF DECEASED (Type or Print): ANTHONY G. CUSIMANO

2. DATE OF DEATH: July 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3012 Harford Road

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3012 Harford Road 9-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Mar. 11, 1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Cusimano

14. MOTHER'S MAIDEN NAME: Thomasina Arena

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Capitolia Cusimano — ADDRESS: 3012 Harford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B) Heart Exhaustion
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ab 1942 / 1 day

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-10 19 47, *to* 7-6- 19 49, *that I last saw the deceased alive on* 7-6- 19 49 *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ralph Grossfeld M. D.

23B. ADDRESS: 5401 Belair Rd

23C. DATE SIGNED: 7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-11-49	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 9 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Leonard J. Ruck, 5305 Harford Road.

VS 150

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G76136

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1 G76136

Registered No.

1. NAME OF DECEASED (Type or Print) William Gatzke

2. DATE OF DEATH July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2607 GIBBONS Ave. 27-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	October 1, 1882	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired (Cabinet Maker)		Germany	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? Gatzke	?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		MRS. Bertha Gatzke	2607 Gibbons Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs 35'
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 8 1949, to July 8 1949, *that I last saw the deceased alive on* July 8, 1949, *and that death occurred at* 1 55 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John Allen Spitzl Jr. M. D.	Mercy	7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-11-49	Moreland Pk	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9 - 1949	Huntington Williamsville	Leonard J Cuck	5305 Harford

VS 150

94a

G76137 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 v 0 1

G76137 Registered No.

1. NAME OF DECEASED (Type or Print) Louis Pfalzgraf

2. DATE OF DEATH July 6-49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Maryland 9 0 ✓
D. STREET ADDRESS (If rural, give location) 4214 Hartford Terrace

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4214 Hartford Terrace

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 7 1877
9. AGE (In years last birthday): 71 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Treas + Sec'y
10B. KIND OF BUSINESS OR INDUSTRY: Balto. Stamp Ex. Co
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick Pfalzgraf
14. MOTHER'S MAIDEN NAME: Louise J. Holzerman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 215-09-2141
17. INFORMANT: Emma L. Pfalzgraf — ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion
DUE TO
(B) Arteriosclerotic C.V.D.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* [illegible], 19[illegible], to July, 1949, *that I last saw the deceased alive on* July 5, 1949, *and that death occurred at* 4.30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: 4218 Hartford Terrace
23C. DATE SIGNED: 7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 9 49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. R. Gilbert & Son
ADDRESS: 1305 Eutaw Place 17 93

VS 150

G76138

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59

G76138

Registered No.

1. NAME OF DECEASED (Type or Print) Charles C. Webb

2. DATE OF DEATH July 6 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2612 W. Fairmount Ave

c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2612 W. Fairmount Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	July 14-1885	63 64	—	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dental - Tech.	Dental - Lab.	Aberdeen, Scotland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Webb	Margaret Baxter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	213-03-5537	Charles C. Webb Jr	- Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 3 yr.

DUE TO

(B) Arteriosclerosis — 7

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/6, 1949 *to* 7/6, 1949, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph L. Blum M. D.	115 N. Calvert St	7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 9-49	Moreland Manor	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9- 1949	Huntington Williams, M.D.	F. B. Wippert & Son	1310 1300 Eutaw Place 17

VS 150

G76139

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76139

1. NAME OF DECEASED (Type or Print) KAHLER, LOUIS

2. DATE OF DEATH 7/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP.

c. Length of stay in Baltimore 82 Yrs. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY BALT.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALT. 27-16
D. STREET ADDRESS (If rural, give location) 4517 PARK HTS.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	MARRIED	AUG. 12, 1862	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Real Estate	Self	GERMANY	U.S.

13. FATHER'S NAME: John J. Kahler

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Smidt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	none	Hosp. Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — 2 days
DUE TO
(B) Coronary thrombosis
DUE TO
(C) Arteriosclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/3, 1949 *to* 7/5, 1949, *that I last saw the deceased alive on* 7/5, 1949 *and that death occurred at* 12:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert Lowlen M. D.	Sinai Hosp.	7/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/8/49	Mt. Olive	Randalstown, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 9 - 1949	Emma Jean Williams, M.D.	H. V. Lennon Sr. 4611 Park Hgts. Ave.

VS 150

93D

G76140

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76140 Registered No.

1. NAME OF DECEASED (Type or Print) Anna C. Roeder

2. DATE OF DEATH July 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3633 Reisterstown Road,

C. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3633 Reisterstown Road. 15-14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	July 3, 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Michael Beirne

14. MOTHER'S MAIDEN NAME: Catherine Campbell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	none	W.A.Roeder,Sr.3633Reisterstown Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis. — 3 min.

DUE TO

(B) generalized arteriosclerosis — 7 Year

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Jan, 1935, to 7/7, 1949 that I last saw the deceased alive on 7/6, 1949, and that death occurred at 3.40 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert L. Mortimer Jr M. D.	2706 St. Paul St.	7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/11/49	Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9 - 1949	Huntington Williams, M.D.	Sr. Verna Lemmon.	4611 Park Heights

VS 150

Effect of Arteriosclerosis

94a

BIRTH NO. 76141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 76141

1. NAME OF DECEASED (Type or Print): Wallie Reitz or (Walburga Reitz) — 2. DATE OF DEATH: 7-6-49.

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Beetz 27-16

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

b. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 3401 Virginia Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	single	Aug. 3, 1888	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
self-employed	Confect. Store	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Emile Reitz

14. MOTHER'S MAIDEN NAME: Elizabeth Benzing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		none	Hospital Records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia.
DUE TO
(B) Heart disease.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-6-49, 19__, *to* 7-6-49, 19__, *that I last saw the deceased alive on* 7-6-49, 19__, *and that death occurred at* 7:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert P. Holm M. D.	University Hosp	7-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/9/49	Holy Redeemer Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 9 - 1949	Thurston Williams, M.D.	C. J. Lennon	4611 Park Hgts. Ave.

VS 150

108

G76142

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

410

G76142

Registered No.

1. NAME OF DECEASED (Type or Print): EDITH M. HARRISON

2. DATE OF DEATH: July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2118 Bolton St.
c. Length of stay in Baltimore: 72 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2118 Bolton St. 1310

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	June 15, 1870	79 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas H. Harrison
14. MOTHER'S MAIDEN NAME: Marie L. Beauchamp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Bernard R. Youngman ADDRESS: Mt'l. Bnk. 1508 First

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myo-endocarditis involving mitral and aortic valves; cardiac hypertrophy and dilatation
DUE TO
(B) with arteriosclerosis. Terminated in coma and congestive failure
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 mo.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 11, 1949, *to* July 8, 1949, *that I last saw the deceased alive on* 7-7-, 1949, *and that death occurred at* 3:20 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Maurice E. Shamer M.D.
23B. ADDRESS: 3300 W. North Ave
23C. DATE SIGNED: July 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/11/49	Lorraine Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 9 - 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

92D

G76143

BC: 49-13910 BALTIMORE CITY HEALTH DEPARTMENT 544 G76143

BIRTH NO. Adelbert C. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) Baby Boy VON MAUCHER the 3rd — 2. DATE OF DEATH 7/9/49

3. PLACE OF DEATH: a. Baltimore City, Maryland Sinai — b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE — B. COUNTY — 715 Brookwood Rd

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balt md

D. STREET ADDRESS (If rural, give location) 28-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Single	July 4. 1949			5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Balt

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME adelbert C Von mauchen

14. MOTHER'S MAIDEN NAME Duthea M Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS Hosp. Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH**

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Ht. Dis — INTERVAL BETWEEN ONSET AND DEATH 4 dys

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A), STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/6/49, 19__, *to* 7/9/49 19__, *that I last saw the deceased alive on* 7/9/49 19__ *and that death occurred at* 4:00 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lee N. Kastner M. D.	Sinai Hosp	7/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	July 10	Chesbrug Cemetery Ind Co Pa.	Ind Co Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 9- 1949 — REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR — ADDRESS: Harry H Witzky 4101 Edmondson ave. 15E

VS 150

G76144 BALTIMORE CITY HEALTH DEPARTMENT 153 G76144
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): ELLEN G. GAFFNEY
2. DATE OF DEATH: July 9. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3047 Brighton St 16-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Apr 7. 1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Mass	

13. FATHER'S NAME: George C Campbell
14. MOTHER'S MAIDEN NAME: Mary G Dennis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		None

17. INFORMANT: David A Gaffney ADDRESS: 3047 Brighton St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cancer of Descending Colon
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-25-49.	Cancer of Descending Colon	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-25-49, 19__, *to* 7-9-49, 19__, *that I last saw the deceased alive on* 7-9-49, 19__, *and that death occurred at* 7 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James A. Parker M. D.	West. Balto Gen Hosp	7-9-49

23A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/11/49	Mt Pleasant	Gloucester Mass

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	26. ADDRESS
JUL 10 1949	Huntington Williams, M.D.	Wilson Co Inc	627 N Pond St

VS 150

46E

G76145

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

91

G76145

Registered No.

1. NAME OF DECEASED (Type or Print) Luther KYLE

2. DATE OF DEATH July 9. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 271 Carey St

C. Length of stay in Baltimore — Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 518 N Port St

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Sept 15 1870

9. AGE (In years last birthday) 78 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Attorney at Law

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Robert Kyle

14. MOTHER'S MAIDEN NAME Angelina Suter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

16. SOCIAL SECURITY NO.

17. INFORMANT Mason Kyle ADDRESS 518 N Port St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of scalp both ears — INTERVAL BETWEEN ONSET AND DEATH 4 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1949, *to* July 9, 1949, *that I last saw the deceased alive on* July 7, 1949, *and that death occurred at* 8.25A m., *from the causes and on the date stated above.*

23A. SIGNATURE Melvin N. Borden M. D.

23B. ADDRESS 2030 W. Fayette St

23C. DATE SIGNED July 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal

24B. DATE 7/10/49

24C. NAME OF CEMETERY OR CREMATORY Rest Hope

24D. LOCATION (City, town, or county) Stillwell, Okla (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 10 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR Wilson

ADDRESS 1217 N Port St

VS 150

53

G76146

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51 G76146

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Nusbaum, Rose

2. DATE OF DEATH July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai

C. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3821 Granada Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	married		79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Leek Sigmund
14. MOTHER'S MAIDEN NAME Shamsal

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Samuel Nusbaum ADDRESS 3821 Granada

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intestinal Obstruction
DUE TO
(B) Intestinal Obstruction
DUE TO
(C) Cardiac Failure primary

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
to mitral stenosis + insufficiency

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 2, 1949 *to* July 8, 1949 *that I last saw the deceased alive on* July 8, 1949, *and that death occurred at* 6 [illegible] m., *from the causes and on the date stated above.*

23A. SIGNATURE Gadson M. D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-10-49
24C. NAME OF CEMETERY OR CREMATORY Beth Tfiloh
24D. LOCATION (City, town, or county) (State) Dallo Md
DATE RECEIVED BY LOCAL REGISTRAR JUL 10 1949
SIGNATURE [illegible]
25. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

VS 150

92B

BIRTH NO. G76147

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76147 47 Registered No.

1. NAME OF DECEASED (Type or Print) BENJAMIN BURGAN

2. DATE OF DEATH 7-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt Sinai Home

c. Length of stay in Baltimore 47 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-13
D. STREET ADDRESS (If rural, give location) 2815 Ridgewood Ave

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH
9. AGE (In years last birthday) 83 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob

14. MOTHER'S MAIDEN NAME Freida

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Meyer Burgan ADDRESS 4148 Pimlico Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/10 19 49 *to* 7/8 19 49 *that I last saw the deceased alive on* 7/8 19 49 *and that death occurred at* ✓ m. *from the causes and on the date stated above.*

23A. SIGNATURE M. Shadekul M. D.
23B. ADDRESS 2225 Linden Ave
23C. DATE SIGNED 9/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-10-49
24C. NAME OF CEMETERY OR CREMATORY Hebrew Young Men
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 10 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eutaw Pl

83B

G76148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

42 0.1 G76148

BIRTH NO. G76148 Registered No.

1. NAME OF DECEASED (Type or Print) ISAAC BERMAN

2. DATE OF DEATH 7-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 103 No Milton Ave

c. Length of stay in Baltimore 65 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 103 No Milton Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married		71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Grocer	Russia	

13. FATHER'S NAME Not Known

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Dora Berman	103 N Milton

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 min

DUE TO

ANTECEDENT CAUSES
(B) arterio sclerosis — ?

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 29 1949 *to* July 9th 1949, *that I last saw the deceased alive on* 7/9th 1949 *and that death occurred at* 12 45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. J. Faulkner M. D.	600 N. Milton Ave	7/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-10-49	Beth Tfiloh	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 10 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 158

94a

G76149 BALTIMORE CITY HEALTH DEPARTMENT G76149

BIRTH NO. G76149 **CERTIFICATE OF DEATH** 294 Registered No.

1. NAME OF DECEASED (Type or Print) MRS ANNA Mc AULIFFE

2. DATE OF DEATH 7.8.49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital. Baltimore - Maryland.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore 2 (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 867 Mc Alleen St 10-0Y

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	White	Widowed		41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Poland	

13. FATHER'S NAME Max

14. MOTHER'S MAIDEN NAME Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO		

17. INFORMANT Frank Cohen ADDRESS 1568 Morland Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week.

DUE TO

(B) Polycythaemia Vera

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7. 1. 49 *to* 7. 8 *, 19*49 *that I last saw the deceased alive on* 7. 8 *, 19*49 *and that death occurred at* 6:30p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R Bettin M. D.	Sinai Hospital - Baltimore	7.8.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-10-49	Hebrew Mt Carmel	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 10 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

843

838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76150 Registered No. 1 G76150

1. NAME OF DECEASED (Type or Print) JOHN S. ALBERT

2. DATE OF DEATH July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
St. Agnes Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore
(If outside corporate limits, write RURAL and give township) 25-3
D. STREET ADDRESS (If rural, give location) Claremont Hotel, Union Stock Yards

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Divorced	Nov 23 1872	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10B. KIND OF BUSINESS OR INDUSTRY: Claremont Hotel

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Francis Albert

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: W.Spaulding Albert 5 E 33rd St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteio-sclerotic C.V. Disease
DUE TO
(B)
DUE TO
(C)

II
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE Emil L Beyer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED July 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 12 1949	Woodlawn	Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Henry H. Simmons

ADDRESS: 4204 Ridgewood Ave

931

Correct age is especially important. Physicians, please make sure.

G76151

BIRTH NO. G76151

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76151

1. NAME OF DECEASED (Type or Print): Annie E Eepley

2. DATE OF DEATH: July 8 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hood Nursing Home
C. Length of stay in Baltimore: 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY 233 S. Dallow St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 233 S. Dallow St. 20-06

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Jany 18 1877
9. AGE (In years last birthday): 72
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Elkridge Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Benjamin F. Paul
14. MOTHER'S MAIDEN NAME: Margaret ——

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Herman Sartoff ADDRESS: 8 Stanley Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(B) Cerebral Thrombosis — 6 wks?
DUE TO
(C) Generalized arteriosclerosis — 10 yrs?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 8, 1949, to July 8, 1949, *that I last saw the deceased alive on* July 8, 1949, *and that death occurred at* 3.30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis H Cohen M. D.
23B. ADDRESS: 5901 Park Heights Ave
23C. DATE SIGNED: July 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 11 1949
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Harry J Himmelrich ADDRESS: 1704 Edgewood

VS 150
JUL 10 1949

83B

G76152 BALTIMORE CITY HEALTH DEPARTMENT X G76152

BIRTH NO. CERTIFICATE OF DEATH 583 Registered No.

1. NAME OF DECEASED (Type or Print) Emory Loudermilk

2. DATE OF DEATH July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) (Rural) Ellicott City, Md.
D. STREET ADDRESS (If rural, give location) Route 2 Centenial Lane

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore 3 ~~Years~~ ~~Months~~ Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	March 26, 1902	47	3	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dye Room	Woolen Factory	Richwood, West Va.	U.S.A.

13. FATHER'S NAME Simeon Loudermilk

14. MOTHER'S MAIDEN NAME Virginia F. Snell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	— — —	233-18-2230	Mrs. Emory Loudermilk	Ellicott City Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Hepatitis c Acute yellow
DUE TO Atrophy suspected

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Rheumatic C-V. Disease

INTERVAL BETWEEN ONSET AND DEATH: 3 Weeks

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 5, 1949 *to* July 8, 1949, *that I last saw the deceased alive on* July 8, 1949, *and that death occurred at* 2:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Highlawer M. D.	University Hospital	7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 11, 1949.	Baptist Church Cemetery	Lisbon Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 10 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Easton Sons ADDRESS Ellicott City, Md.

VS 150

125a

Dr. Siscovick G76153 ✓ G76153
1429 N. Fayette

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Lucy Arminta Ruhl	2. DATE OF DEATH: July 7, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 105 Dennison Street c. Length of stay in Baltimore: Yrs. Mos. Days	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 105 Dennison Street 20-07
5. SEX: female 6. COLOR OR RACE: white 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed	8. DATE OF BIRTH: Nov. 21, 1879 9. AGE (In years last birthday): 69 If Under 1 Year: Months / Days If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home 10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Chestertown, Md. 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Aquilla Fogwell	14. MOTHER'S MAIDEN NAME: Emily Lusby
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.	17. INFORMANT: Mrs. Hazel Whittler ADDRESS: 105 Dennison

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Colon. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Chronic myocarditis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec; 1948 *to* July 7, 1949 *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Milton Siscovick M. D.	23B. ADDRESS: 1429 W Fayette St	23C. DATE SIGNED: 7/9/49
24A. BURIAL, CREMATION, REMOVAL (Specify): Burial	24B. DATE: 7-11-49	24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
		24D. LOCATION (City, town, or county) (State): Baltimore, Md.
DATE RECEIVED BY LOCAL REGISTRAR: JUL 10 1949	REGISTRAR'S SIGNATURE: Huntington Williams, M.D.	25. FUNERAL DIRECTOR: Leonard J. Ruck, 5305 Harford Road. (ADDRESS)

VS 150

46E

G76154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76154 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY J. ALTEVOGT 181

2. DATE OF DEATH 7-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 3015 Orlando Ave 27-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	married	Sept. 12-1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Self employed		Balto Md	

13. FATHER'S NAME Henry Altevogt

14. MOTHER'S MAIDEN NAME Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Altevogt	3015 Orlando

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Continued bleeding per Penis and uncontrollable — INTERVAL BETWEEN ONSET AND DEATH: 1-2 wks.
DUE TO diabetes

(B) Carcinoma of bladder — 2 yrs +
DUE TO

(C) diabetes mellitus — 2 yrs +

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-29-49	Carcinoma of bladder	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 1949, *to* July 9, 1949, *that I last saw the deceased alive on* Jul. 9, 1949, *and that death occurred at* 11 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert L. Spees M.D.	Univ. Hosp. Balt 2d.	7/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-11-49	Moreland Pk	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 10 1949	Huntington Williams, M.D.	Leonard J. Ruck	5305 Harford

52B

CERTIFICATE CORRECTED 2-21-49 ✓

076155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 076155

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LOUIS SILVERMAN

2. DATE OF DEATH July 9th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2802 Lawina Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Lifetime Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE same B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) 2802 Lawina Rd. 28-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last Birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Male	White	Married	mch 3rd. 1878.	71	4	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Sanitary Supplies	Balto. Md.	

13. FATHER'S NAME Harris Silverman,

14. MOTHER'S MAIDEN NAME Buckner.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Minerva K. Silverman ADDRESS 2802 Lawina Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Oedema — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

DUE TO

(B) Myocardial Decompensation — 3 mos

DUE TO

(C) Coronary Thrombosis — 11 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 9th, 1949 *to* July 9th, 1949, *that I last saw the deceased alive on* July 8, 1949, *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. W. Jacobsen M.D. M. D.	2310 Eutaw Place.	7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 11, 1949	Arlington Cemetery	4300 W Rodgers Ave

DATE RECEIVED BY LOCAL REGISTRAR: JUL 10 1949

REGISTRAR'S SIGNATURE: Hunter Williams, M.D.

25. FUNERAL DIRECTOR: D. Ar Sondheim Inc. ADDRESS: 1902 Eutaw Pl.

VS 150

93D

576

G76156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76156 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SEBASTIAN CHRISTOPHER FRANK.

2. DATE OF DEATH JULY-10,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore B. COUNTY Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 31 - 605
D. STREET ADDRESS (If rural, give location) 1731 E. Fairmount Ave.

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH July 15, 1901 | 9. AGE (In years last birthday) 47 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal worker

10B. KIND OF BUSINESS OR INDUSTRY Sheet metal work

11. BIRTHPLACE (State or foreign country) Hollidaysburg, Penna.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Frank

14. MOTHER'S MAIDEN NAME Unknown Blendell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 161-12-7366

17. INFORMANT Mrs. Elsie Frank ADDRESS 1731 E Fairmount Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Peritonitis

DUE TO

(B) Cause (?)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Portal cirrhosis of liver

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-5, 19 49, *to* 7-10, 19 49, *that I last saw the deceased alive on* 7-10, 19 49 *and that death occurred at* 2:40 Am., *from the causes and on the date stated above.*

23A. SIGNATURE Frederick Adler, M. D. | 23B. ADDRESS 1 Truman Pkwy | 23C. DATE SIGNED 7-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24B. DATE July 10, 1949 | 24C. NAME OF CEMETERY OR CREMATORY Newry, Penna. | 24D. LOCATION (City, town, or county) (State) Penna.

DATE RECEIVED BY LOCAL REGISTRAR JUL 10 1949 | REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1217 St Paul St. Balto., Md.

1246

6157 ✓ X 676157

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
6-10
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harwood Hastings

2. DATE OF DEATH July 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Dorchester

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Galestown

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	1-20-1873	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Hastings

14. MOTHER'S MAIDEN NAME Theresa Smoot

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Uremia	7 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Urinary retention due to prostatic obstruction	3 wks.
	(C) dehydration and acidosis	1 wk.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	arteriosclerotic heart disease	7 yrs.

19A. DATE OF OPERATION None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-8, 1949 *to* 7-10, 1949, *that I last saw the deceased alive on* 7-10, 1949, *and that death occurred at* 4:05 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE W. W. S. Butler M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED 7/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial.

24B. DATE 7-13-49

24C. NAME OF CEMETERY OR CREMATORY Galestown.

24D. LOCATION (City, town, or county) (State) Galestown Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1949

REGISTRAR'S SIGNATURE Washington Williams, M.D.

25. FUNERAL DIRECTOR J. J. Frampton Son ADDRESS Federalsburg Md

VS 150

937

G76158 GM 86998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76158 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ximena Logan

2. DATE OF DEATH July 8- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3650 Beach Ave. 13-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	May 19 1857	92Yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD.	

13. FATHER'S NAME Eli Cosgrove

14. MOTHER'S MAIDEN NAME Elizabeth Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Records B.C.H. 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Probable Cerebral Vascular Accident	
	DUE TO Far Advanced Generalized Arteriosclerosis	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Strangulated right inguinal hernia, Multiple Kidney Stones, Carcinoma of nose	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	—	YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3- 17- , 1944, *to* 7- 8- , 1949 *that I last saw the deceased alive on* 7- 8- , 1949, *and that death occurred at* 11.45 *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T. S. Logan M. D.	B.C.H 4940 Eastern Ave.	7-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/11/49	London Park	Baltimore MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams, M.D.	Wilhom Col Dnd	1217 E Pratt St

VS 150

53

G76159

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76159

1. NAME OF DECEASED (Type or Print) Charles B. Graves

2. DATE OF DEATH July 9. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2521 Hamilton Ave

c. Length of stay in Baltimore 29 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2521 Hamilton ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	White	Married	Oct 3. 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Real Estate	Penn R. R.	Philadelphia, Pa	U. S. A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME Anna Baugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
Yes	W W I.	717-07-9535

17. INFORMANT Helen Graves ADDRESS 2521 Hamilton Ave Balto-Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour

DUE TO

(B) Chronic Myocarditis — 2 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 16, 1949 *to* July 9th, 1949, *that I last saw the deceased alive on* July 1st 1949, *and that death occurred at* 1:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. W. Gordy M. D.	5106 Harford Road	7-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/12/49	Moreland Mem. Park	Taylor Ave. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Matthews, M.D.	Howard V. Blight	6009 Harford Road

VS 150

93

G76150 G76150

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Charles Councilman

2. DATE OF DEATH: 7-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital

c. Length of stay in Baltimore: life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Raspeburg, Md.
D. STREET ADDRESS (If rural, give location): 10 Councilman Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	single	Sept. 23rd, 1872	76	9	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Farmer		Baltimore County, Md.	USA

13. FATHER'S NAME: Robert Councilman

14. MOTHER'S MAIDEN NAME: Louisa C. Fitch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Mrs. Bessie Bradley ADDRESS: 1 McCormick Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral haemorrhage.

DUE TO

(B) Hypertensive cardio-vascular renal disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-1 *1949, to* July 10 *1949 that I last saw the deceased alive on* July 10 *1949, and that death occurred at* 2:20 *A.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leonard Fischer MD M. D.	West Baltimore Gen'l Hosp	July 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/13/49	Councilman Burying Grounds	Raspeburg, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams, M.D.	Lasselen Funeral Home	7401 Belair Road

VS 150

131a

Hospital Disposal

G76161

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 49-93847

CERTIFICATE OF DEATH

Registered No. G76161

1. NAME OF DECEASED (Type or Print): Baby Girl Carter

2. DATE OF DEATH: July 7 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 401 N. Arlington Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Child	7-7-49				7	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: Frederick Carter

14. MOTHER'S MAIDEN NAME: Eileen Burns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity. Traumatic delivery.
DUE TO Anoxia. Resp. distress. Subarachnoid hemorrhage.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-7 1949 *to* 7-7 1949 *that I last saw the deceased alive on* 7-7 1949, *and that death occurred at* 4:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Bratousky M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Hosp Disposal	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams, M.D.		

VS 150

160a

G76162

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76162

Registered No.

1. NAME OF DECEASED (Type or Print) Mrs. Sadie Prechtel

2. DATE OF DEATH 7-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Women's Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) Ambassador Apts. 12-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	WIDOWED	1-8-77	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ✓

10B. KIND OF BUSINESS OR INDUSTRY ✓

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Straus

14. MOTHER'S MAIDEN NAME Charlotte Rhode

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) ✓

16. SOCIAL SECURITY NO. ✓

17. INFORMANT — ADDRESS Chas. Sloan Hosp. Del Monico Apts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

DUE TO + Diabetic Comme

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Vascular

DUE TO disease & Diabetes

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-8-49, 19__, *to* 7-9-49, 19__, *that I last saw the deceased alive on* 7-9-49, 19__, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. C. Decker, M.D. M. D.	Women's Hospital	7-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/11/49	Woodlawn Cemy.	Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams M.D.	John E. Mitchell & Son	1900 Eutaw Place

VS 150

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G76163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17°

G76163

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Marguerite S, Grumbine

2. DATE OF DEATH July 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2312 Edmondson Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 2312 Edmondson Ave. B. COUNTY Balto. mda

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md.

D. STREET ADDRESS (If rural, give location) 2312 Edmondson Ave. 16-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	Jany 4, 1889	60	6		4	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	-------	Balto. Md.	U.S.A.

13. FATHER'S NAME: John Stephan

14. MOTHER'S MAIDEN NAME: Emma O. Ludwig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no.		no

17. INFORMANT: Edwin R. Grumbine ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Toxaemia from Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

DUE TO

(B) Carcinoma of Breast & Left Lung — 4½ yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Spring 1945	Carcinoma of Left Breast, - Breast removed	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M Bennett Hood M. D.	2200 Garrison Blvd	July 9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 11/49	Parklawn Cemetery	at Pikesville

DATE RECEIVED BY LOCAL REGISTRAR: JUL 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John O. Mitchell & Son ADDRESS: 1900 Eastern Place

VS 150

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G76164

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

173 Registered No. G76164

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Agnes Elois Johnson

2. DATE OF DEATH July 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's

c. Length of stay in Baltimore 16 yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1240 Ashland Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	Colored	Single	2/5/15	34		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Johnson

14. MOTHER'S MAIDEN NAME Louise Simpson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Louise Johnson ADDRESS 1240 Ashland Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute cardiac syncope	
	DUE TO (B) Myocardial irritability	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Fibromyomata uteri	

19A. DATE OF OPERATION 7-9-49
19B. MAJOR FINDINGS OF OPERATION Fibromyomata uteri
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Operative death
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-8, 1949, to 7-9, 1949, *that I last saw the deceased alive on* 7-9, 1949, *and that death occurred at* 12:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE J. Joseph Kraji M. D.
23B. ADDRESS 1400 N. Caroline St
23C. DATE SIGNED 7-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/12/49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery
24D. LOCATION (City, town, or county) (State) A. A. Co. Md.
25. FUNERAL DIRECTOR ADDRESS Robert E. Williams 1515 McElderry St

DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1949
REGISTRAR SIGNATURE Curtis Williams, M.D.

VS 150

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G76165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76165 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edwin F. Leister

2. DATE OF DEATH July-10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

C. Length of stay in Baltimore 82 Yrs. 4 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3019 Presstman St #16 16-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Male	White	Widowed	Sept 24, 1866	82				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unKnown

10B. KIND OF BUSINESS OR INDUSTRY unknown

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Daniel Leister

14. MOTHER'S MAIDEN NAME Catherine MANAHAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT daughter Mrs Harold Walker ADDRESS as above

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Decompensation	unknown about 3-4 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) + gangrenous ileitis	
	DUE TO (C) ACVD	unknown
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Chronic passive congestion	

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) , m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 9, 1949 *to* July 10, 1949 *that I last saw the deceased alive on* July 10, 1949, *and that death occurred at* 6:00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE Marguerite Louise Candler, M.D.

23B. ADDRESS Maryland General Hospital

23C. DATE SIGNED 7-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE JULY 12, 1949

24C. NAME OF CEMETERY OR CREMATORY WOODLAWN CEM.

24D. LOCATION (City, town, or county) (State) BALTO., MD.

DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR WM. J. TICKNER & SONS

ADDRESS BALTO., MD.

VS 150

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G76166

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76166

Registered No.

1. NAME OF DECEASED (Type or Print)	KATE G. SCOTT
2. DATE OF DEATH	July 8, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	Ashburton Nursing Home 3520 Hilton St.
C. Length of stay in Baltimore	Yrs. - Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Md.
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	2402 Roslyn Ave.
5. SEX	female
6. COLOR OR RACE	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	widowed
8. DATE OF BIRTH	June 29, 1859
9. AGE (In years last birthday)	90 yrs.
If Under 1 Year: Months Days	
If Under 24 Hours: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	housewife
10B. KIND OF BUSINESS OR INDUSTRY	home
11. BIRTHPLACE (State or foreign country)	Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME	Daniel Kenley Shane
14. MOTHER'S MAIDEN NAME	- Loane
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	no
16. SOCIAL SECURITY NO.	no
17. INFORMANT	Mrs. Mary A. Scott
ADDRESS	2402 Roslyn Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Cerebral hemorrhage & paralysis — 5 days

DUE TO

(C) Arterio-sclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	None
19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?	YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	m.
21E. INJURY OCCURRED	WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* July 3, 1949 *to* July 8, 1949 *that I last saw the deceased alive on* July 8, 1949, *and that death occurred at* 8 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	Dallas S. Tibbitt M. D.	23B. ADDRESS	2220 Garrison Blvd.
23C. DATE SIGNED	July 9/49		
24A. BURIAL, CREMATION, REMOVAL (Specify)	Burial	24B. DATE	7/11/49
24C. NAME OF CEMETERY OR CREMATORY	Greenmount Cem.	24D. LOCATION (City, town, or county) (State)	Baltimore, Md.
DATE RECEIVED BY LOCAL REGISTRAR	JUL 11 1949	REGISTRAR'S SIGNATURE	Huntington Williams, M.D.
25. FUNERAL DIRECTOR	WM. J. TICKNER & SONS	ADDRESS	Balto., Md.

VS 150

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G76167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76167

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Eugene E. Woolford

2. DATE OF DEATH: July 9th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital DOA
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Dorchester
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cambridge
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	October 13-1870	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Dorchester County, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Asbury Woolford	Lovina Tall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	Mr. Kenneth R. Thomas	Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-vascular Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
William G. Hebeck M.D.		July 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
Burial	July 12th 1949	Old Trinity	Church Creek, Dorchester Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Deputy for Williams, M.D.	Kenneth R. Thomas	Cambridge, Md.

VS 151

correct age is especially important. If unknown, please write

93

76168 X ✓ 76 G76168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C 49-13503 Registered No.

1. NAME OF DECEASED (Type or Print) Baby Boy Shiflett

2. DATE OF DEATH 6/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Edgemere, Maryland
D. STREET ADDRESS (If rural, give location) 2634 Edgemere Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	6/28/49				10	15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Arnold Shiflett
14. MOTHER'S MAIDEN NAME Beulah Daff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
10 hrs. 15 m

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/28/49, 19__, *to* 6/28/49, 19__, *that I last saw the deceased alive on* 6/28/49 19__, *and that death occurred at* 3 A m., *from the causes and on the date stated above.*

23A. SIGNATURE J. L. Sollitto M. D.
23B. ADDRESS 1213 Light Street
23C. DATE SIGNED 7/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY [illegible] UNIVERSITY MEDICAL SCHOOL JUL 7 1949
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Commissioner of Health
ADDRESS

VS 150

159

BARNES X V

76169

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76169

1. NAME OF DECEASED (Type or Print): Mary Ann Barnes

2. DATE OF DEATH: 7/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3500 Berwyn Ave
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Rural - Finksburg RFD #2
D. STREET ADDRESS (If rural, give location): Gamber Md

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	1-14-1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Parrish	Mary Jane Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		none	Earle W. Jordan	Finksburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
C. J. Lubinski M.D.		7/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY	24D. LOCATION (City, town, or county) (State)
BURIAL	7-13-1949	Bethesda	Gist, Carroll Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Hillhouse, M.D.	C. M. Waltz,	Winfield, Md.

VS 151

94a

G76170 X ✓ 917.7 G76170

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Elizabeth C Fisher — N-948. ✓
2. DATE OF DEATH: July 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — W Balto Gen Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Masonic Home
B. COUNTY: Balto, County
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cockeysville, Md.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	June 22, 1871	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lancaster County, Va
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William D Clark
14. MOTHER'S MAIDEN NAME: Elizabeth C Root
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Masonic Home Records, Cockeysville, Md. — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) 2°+3° Burns of Face Rt Arm Body — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO & Legs
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
For: Robert McFadden M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Masonic Home Cockeysville Md.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-8-49 3:30 P.m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Pt was found in Tub of Hot Water.

22. *I hereby certify that I attended the deceased from* 7-7-49, 19__, *to* 7-9-49, 19__, *that I last saw the deceased alive on* 7-9-49, 19__, *and that death occurred at* 11:12 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: James A. Dawkins M. D.
23B. ADDRESS: Wst. Balto Gen Hosp
23C. DATE SIGNED: 7-9-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/13/49
24C. NAME OF CEMETERY OR CREMATORY: Green Mount
24D. LOCATION (City, town, or county) (State): Baltimore, Md
DATE RECEIVED BY LOCAL REGISTRAR: JUL 11 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: Wilhelm & Son — ADDRESS: 1211 Pond St

VS 150

1-1

G76171

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76171

1. NAME OF DECEASED (Type or Print): John Everett Robinson

2. DATE OF DEATH: July 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4811 Gwynn Oak Ave. Baltimore 7

c. Length of stay in Baltimore: Four (4) Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Cecil
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aikin
D. STREET ADDRESS (If rural, give location): Perryville R.D.

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	July 23, 1887	61	11 / 16	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
B&O Signal Maint. Mech.	Railroad	Baltimore, Maryland	United States

13. FATHER'S NAME: John Henry Robinson

14. MOTHER'S MAIDEN NAME: Susana Parker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

SOCIAL SECURITY NO. 205-07-5135

17. INFORMANT: Wife (Mrs. Viola Robinson) ADDRESS: Same As deceased

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of the Bladder	5 years
	DUE TO	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Coronary Thrombosis	3 months

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
August 1945	Carcinoma of the Bladder	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 6, 1949 *to* July 9, 1949, *that I last saw the deceased alive on* July 9, 1949 *and that death occurred at* 6.40 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Millard T. Trabaud Jr. M.D.	3400 Woodbine Ave. Balt. 7	7/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 12, 1949	Loudon Park Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams, M.D.	E. Willis Lamoreau	4510 Liberty Heights Ave.

VS 150

52 B

G76172

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

581.0

G76172

Registered No.

1. NAME OF DECEASED (Type or Print): Martha P S Thurow

2. DATE OF DEATH: July 9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 441 N Patterson Pk
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 3
D. STREET ADDRESS (If rural, give location): 441 N Patterson Park Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	married	Nov 23 1880	68	7	16		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Germany	

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: Martha Harker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Herman Thurow	228 N Eugene Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis Liver — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-6, 1949, *to* 7-9, 1949, *that I last saw the deceased alive on* 7-9, 1949, *and that death occurred at* 10 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L Vogel Jr M. D.	260 E. Northwood St.	7-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 11/49	St Matthews	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Cunnington for Williams, M.D.	Ulrich Funeral Home	2008 Orleans

VS 150

124 C

G76173

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76173

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louisa P. Smallwood

2. DATE OF DEATH: 7/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5132 Edmondson ave
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-04
D. STREET ADDRESS (If rural, give location): 5132 Edmondson ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W	Widow	Jan. 22, 1865	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H.W.	Own Home	Balto. Md	

13. FATHER'S NAME: Charles Braun

14. MOTHER'S MAIDEN NAME: Margaret —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—		

17. INFORMANT: Mrs. Harry Koehnle ADDRESS: 5132 Edmondson Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 Days
DUE TO
(B) Hypertensive Cardio-Vascular Disease — 20 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
X	X	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
X	X	X

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
X m.	WHILE AT WORK ☐ X NOT WHILE AT WORK ☐	X

22. *I hereby certify that I attended the deceased from* 4 July, 1949 *to* 7 July, 1949, *that I last saw the deceased alive on* 7 July, 1949, *and that death occurred at* 6:35 *p.m., from the causes and on the date stated above.*

22A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward L. S. Krieg, M. D.	4508 Edmondson Village	8 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/11/49	Parkwood -	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Nitz & Co. ADDRESS: 4101 Edmondson Ave

VS 150

93D

G76174
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

584 Registered No. G76174

1. NAME OF DECEASED (Type or Print): Alfred Washington Cooper
2. DATE OF DEATH: July 9. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Md-Gen'l Hosp
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: 70 yrs Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 13-07
D. STREET ADDRESS (If rural, give location): 3736 Elm Avenue #11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	August 9, 1860	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
machinist	Railroad shops	Maryland	USA

13. FATHER'S NAME: William Cooper
14. MOTHER'S MAIDEN NAME: Mary E. Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	Katie Lovell (Sister)	3645 Elm Ave #1

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Arteriosclerotic cardiovascular disease & decompensation	unknown several yrs
DUE TO (B)	Acute suppurative & chronic cholecystitis & lithiasis & cholangiitis	about one month
(C)		
	Chronic passive congestion, jaundice,	unknown

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-7 1949 *to* 7-9, 1949 *that I last saw the deceased alive on* 7-9, 1949, *and that death occurred at* 8 30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marguerite Louise Candler M. D.	Md General Hospital	7/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	July 12-1949	St. Mary's (Hamden)	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

937

correct age is especially important for persons over 65

G761175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 · G761175 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ruth S. Zink

2. DATE OF DEATH July 7th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3230 Kingsley St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3230 Kingsley St.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3230 Kingsley St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Widowed	Oct. 16, 1877	71	8	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Watts
14. MOTHER'S MAIDEN NAME Susanna Sewell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None

17. INFORMANT Cecillia Z. Fink, ADDRESS 6706 Windsor Mill Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 Days

DUE TO

(B) Cardio-Vascular Disease & Hypertension — 10 Years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/11 1948 to 6/8 1949, that I last saw the deceased alive on 6/9 1949, and that death occurred at 5:30 P.M. from the causes and on the date stated above.

23A. SIGNATURE Eliot Wechsler M. D.
23B. ADDRESS 3632 Fredrick Ave
23C. DATE SIGNED 7/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 9, 1949
24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
26. FUNERAL DIRECTOR Fred A. Cole
ADDRESS 1200 W. Lombard St

VS 150

93D

G76176 JL- 60351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76176

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Thomas Harper

2. DATE OF DEATH 6-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore 35 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3945 Greenmount Ave. 9-01

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Sept. 15, 1866
9. AGE (In years last birthday) 82
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Old Aged Pension
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Edward
14. MOTHER'S MAIDEN NAME Adeline Curry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT B. C. H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ XXX

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* 10-24-40, 19__, *to* June 27, 1949, *that I last saw the deceased alive on* June 27, 1949, *and that death occurred at* 8PM *m., from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS 4940 Eastern Ave.
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State) JUL 7 1949

DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1949
REGISTRAR'S SIGNATURE [signature], M.D.
25. FUNERAL DIRECTOR Commissioner of Health ADDRESS

VS 150

93D

G76177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76177

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Benaiah Thornton.

2. DATE OF DEATH: 7-10-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 320 E. 33rd St.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. City
D. STREET ADDRESS (If rural, give location): 320 E. 33rd St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	W	12-27-1864	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Benaiah Thornton

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Webster Turner ADDRESS: Severna Park

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-12, 1942 *to* 7-10-, 1949 *that I last saw the deceased alive on* 7-9-, 1949 *and that death occurred at* 12:[illegible] *from the causes and on the date stated above.*

23A. SIGNATURE: E. W. Peake M. D.

23B. ADDRESS: 4518 Harford Road

23C. DATE SIGNED: 7-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 7-12-1949

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park

24D. LOCATION (City, Town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Flynn & Fleming ADDRESS: 1426 Light St.

VS 150

93E

G76178 ✓ X G76178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

463 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MR. GEORGE H HORSTMAN

2. DATE OF DEATH 10 JULY 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore: ENTIRE LIFE — 56 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2626 HILLCREST AVE; BALT 14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	SEPARATED	AUGUST 19, 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
PAINTER		BALTIMORE	USA

13. FATHER'S NAME: HENRY HORSTMAN

14. MOTHER'S MAIDEN NAME: ELIZABETH POHL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
UNK.	—	Mother - 2626 Hillcrest Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Multiple Pulmonary emboli — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Thrombophlebitis, left leg — 1 week
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. diffuse Pachymeningitis — 4 weeks

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* June 13, 1949, *to* July 10, 1949, *that I last saw the deceased alive on* July 10, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. F. Cox M.D.	Union Memorial Hospital	7-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
Burial	7-13-49	Parkwood	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams, M.D.	Leonard J. Keck	5305 Harford

VS 150

Correct age is especially important. Physician, please write plainly.

81a

G76179

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76179

Registered No.

1. NAME OF DECEASED (Type or Print) Margaret Simpson

2. DATE OF DEATH 7/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. Baltimore, City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 608 S. Paca Street

C. Length of stay in Baltimore 27 Yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, City.
D. STREET ADDRESS (If rural, give location) 608 S. Paca Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	W	5/15/1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Carroll Co., Md.	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Myrtle Scott, ADDRESS 608 S. Paca Street

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH — (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Vascular Accident	6 months
DUE TO		
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 5, 1949 *to* July 9, 1949, *that I last saw the deceased alive on* July 9, 1949, *and that death occurred at* 2-30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Isl H W Watts M. D.	1515 Huntington Ave	7/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/12/49	Mount Auburn Cemetery	Baltimore, City.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams, MD	D. L. Brown & Son	108 W Montgomery St

VS 150

931

G76180

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

99-8 G76180
Registered No.

1. NAME OF DECEASED (Type or Print): Potz, Ike

2. DATE OF DEATH: 10 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Sinai Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai
C. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 113 Augusta St 5-01

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH:
9. AGE (In years last birthday): 69
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Wall Paper
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Meyer
14. MOTHER'S MAIDEN NAME: Esther
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hyman Potts ADDRESS: 4017 Spruce Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARCINOMATOSIS (PRIMARY SITE UNKNOWN)
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 6/28/49
19B. MAJOR FINDINGS OF OPERATION: CARCINOMATOSIS
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-20, 1949 *to* 7-10, 1949 *that I last saw the deceased alive on* 7-10, 1949, *and that death occurred at* 6 25 *p.m. from the causes and on the date stated above.*

23A. SIGNATURE: Eugene P. Berlin M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 10 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-11-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Levinske
ADDRESS: 2100 Eutaw Pl

VS 150

55E

Please write correct age if especially important. Physicians please write plainly.

BIRTH NO. 76181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 76181

1. NAME OF DECEASED (Type or Print): FREDERICK J. WENKER 330

2. DATE OF DEATH: July 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3200 Fleet Street
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 3200 Fleet Street 26-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	July 29, 1887	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engine man	Penna. R.R.	Baltimore, Md.	USA

13. FATHER'S NAME: John Wenker

14. MOTHER'S MAIDEN NAME: Fredericka ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		717-07-8848	3200 Fleet Street - 24 Mrs. Anna M. Wenker

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subdural hemorrhage
DUE TO Subarachnoid hemorrhage
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [x] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3200 Fleet Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 9, 1949 12:10a.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [x]

21F. HOW DID INJURY OCCUR? Fell down stairs (inside home)

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [x], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: William J. McCafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [x] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: July 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/12/49	Oak Lawn Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.

VS 151

BALTIMORE - 13, MARYLAND 186a

Correct age is especially important. Physicians, please write plainly.

76182

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 076182

1. NAME OF DECEASED (Type or Print) JOSEPH JOHN WESTERKAM

2. DATE OF DEATH July 9, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1738 Montpelier Street

C. Length of stay in Baltimore 69 yrs Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1738 Montpelier Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	Aug. 20, 1878	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Printer	New Amsterdam Cas.	Co. Germany	USA

13. FATHER'S NAME: Joseph Westerkam

14. MOTHER'S MAIDEN NAME: Fredericka ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		212-07-0659

17. INFORMANT 1738 Montpelier Street Mrs. Flora B. Westerkam

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 Mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — 2 yrs.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 27, 1949 *to* July 9, 1949 *that I last saw the deceased alive on* 7-5-, 1949, *and that death occurred at* 1 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Allen J. Singewald	1613 E. North Ave.	7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/13/49	Baltimore Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 11 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC.

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BALTIMORE - 13, MARYLAND 94a

G76183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76183

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Virgil Thompson

2. DATE OF DEATH: 7/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1517 W. Pratt St

c. Length of stay in Baltimore: 6 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1517 W. Pratt St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	White	Married	4/15/1905	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Hotel	W. Va.	

13. FATHER'S NAME: George W. Thompson

14. MOTHER'S MAIDEN NAME: Rhoda M. Shumate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT	ADDRESS
No	233-30-1986	Beulah M. Thompson	Hargrove

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — Beckley W. Va. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED 7-10-July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 13-1949		Beckley W. Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949		Scott & B. McWaters	Scott & County

VS 151

94a

Please write clearly. Physician: Please fill in all items. Exact age is especially important.

G76184 420.1 G76184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 76184

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN HENRY GUICE

2. DATE OF DEATH: July 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1107 Bayard Street
c. Length of stay in Baltimore: Yrs. - Mos. - Days -

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-02
D. STREET ADDRESS (If rural, give location): 1107 Bayard Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	March 12, 1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	B. & O. R. R.	West Virginia	

13. FATHER'S NAME: John H. Guice

14. MOTHER'S MAIDEN NAME: Caroline Ault

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-	-	705-07-6413	Lottie R. Guice	-

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I	(A) Coronary Occlusion	
	DUE TO	
ANTECEDENT CAUSES	(B) Hypertensive Arteriosclerotic	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO Cardio Vascular Disease	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
-	-	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
-	-	-

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
- m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	-

22. *I hereby certify that I attended the deceased from* July 8, 1949, *to* July 9, 1949, *that I last saw the deceased alive on* July 8, 1949, *and that death occurred at* 7:45A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis Lemmell M. D.	805 Fuselage Avenue	7/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 12, 1949	Western Cem.	Edmondson Avenue

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
July 11, '49	Huntington Williams, M.D.	Edward Toulson,	Washington Blvd.

VS 150

93-D.

G76185 BALTIMORE CITY HEALTH DEPARTMENT G76185
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Nicholas J. Rauscher
2. DATE OF DEATH Sat./7/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1439 Henry St.
c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore (30)
D. STREET ADDRESS (If rural, give location) 1439 Henry St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Sept. 28, 1912	36				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist	Nat'l. Distillers	Corp., Baltimore, Md.	USA

13. FATHER'S NAME Antone Rauscher
14. MOTHER'S MAIDEN NAME Mary Braumbrat

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	216-09-6561	Mrs. Leona Rauscher (Wife)	Same

MEDICAL CERTIFICATION

18.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinomatosis	6 mos.
	DUE TO (B) Carcinoma of Testicle	14 Mos.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
April 1949	Malignancy of Testicle	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 19 49 *to* July 9, 19 49 *that I last saw the deceased alive on* 7/8, 19 49, *and that death occurred at* 8:45 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter Kohn M. D.	102 E. Fort Ave	7/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Tues., 7/12/49	Holy Cross Cemetery	Brooklyn, A.A.Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 11 1949	Christopher Williams, M.D.	A. Howard Evans, 1400 S. Charles St. Baltimore 30, Md.

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51c A. Howard Evans

G76186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76186

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY COTTMAN ELLIS

2. DATE OF DEATH: July 10, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland 203 East Street

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN: Baltimore,
(If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location): 203 East Street 5-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Col.	Widow	Jan. 2, 1870	79 smt		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md	

13. FATHER'S NAME: Phillip Cottman

14. MOTHER'S MAIDEN NAME: Carolina King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C. V. Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23a. SIGNATURE	23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23c. DATE SIGNED
Earl Royer M.D.		7/11/49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/14/49	Mt. Calvary	A. A. County, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams, M.D.	Joseph D. Lobb, Jr.	1304 N. Central Ave

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93D

G76187 ✓X G76187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) George Marshall

2. DATE OF DEATH 7-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital
c. Length of stay in Baltimore one DAY (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Waynesboro
D. STREET ADDRESS (If rural, give location) Route #2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
M	W	Married	Nov. 16, 1887	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER		Pennsylvania	U.S.A.

13. FATHER'S NAME: Simon Marshall

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mr. Walter Y. Grove	Chambersburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intra cerebral Hemorrhage
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-10 ; 1949 *to* 7-11, 1949, *that I last saw the deceased alive on* 7-10, 1949, *and that death occurred at* 2.30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Max Miller MD M. D.	Sinai Hospital	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 13, 1949	Cedar Grove Cemetery	Chambersbury, Penna

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams, MD	WILLIAM J. TICKNER & SONS, INC.	

VS 150

Collect ago if different. Improper, illegible, please write

83a

G76188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

20

G76188

Registered No. G 76188

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CATHERINE SHARPLEY

2. DATE OF DEATH: July 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: 46 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 28-01
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4203 Sherbrook Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	June 14, 1903	46				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	-	Maryland	U. S. A.

13. FATHER'S NAME: Martin W. E. Dippel

14. MOTHER'S MAIDEN NAME: Catherine Connolly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (Husband)	ADDRESS
unkn.	no	none	Mr. Paul H. Sharpley	same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
-	-	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
-	-	-

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
- m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	-

22. *I hereby certify that I attended the deceased from* July 10, 1949, to July 11, 1949 *that I last saw the deceased alive on* July 10, 1949 *and that death occurred at* 3:25 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Frank Snyder III M. D.	Union Memorial Hospital	7/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 13, '49	New Cathedral	Old Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
July 11, '49	Huntington Williams, M.D.	Dippel Bros.,	1800 E. Lombard St

VS 150

44-B

G76189

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

53 G76189

Registered No.

1. NAME OF DECEASED (Type or Print): ELIJAH GRANT

2. DATE OF DEATH: July 7 a 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 27 N. Carey St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — B. COUNTY
626 W Biddle St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-01
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	Negro	S	March 16, 1905	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Hospital Records — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
?	?	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 6 '49 to July 7 '49, *that I last saw the deceased alive on* July 6 '49, *and that death occurred at* 10:55 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. R. Johnson, M.D.	4103 Med. Arts Bldg	7-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 13, 1949	Mt. Auburn	Westport, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Thurlington Williams, M.D.	Charles H. Alexander	1200 McCulloh St. Baltimore, Md.

VS 150

46E

G76190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76190

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sarah L. Feigley

2. DATE OF DEATH 7/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4 Longwood Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1155 Carroll St 21-07

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Widowed	Nov 7th 1872	76	8	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Home	Baltimore Md	

13. FATHER'S NAME
Samuel C Horney

14. MOTHER'S MAIDEN NAME
Margaret A. Wells

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT
Mrs. Florence E. Brown
ADDRESS 2042 N Washington Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO

(B) Arteriosclerosis & — 2 years

DUE TO

(C) Chronic Myocarditis — 2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 1925, *to* July 9, 1949, *that I last saw the deceased alive on* July 9, 1949, *and that death occurred at* 11 0 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert K. Mortimer Jr. M.D.	2706 St Paul St	July 11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/13/49	Oak Lawn Cem	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams, M.D.	Charles P. Towell	2423 Edmondson Ave

VS 150

937

G76191

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76191

Registered No.

1. NAME OF DECEASED (Type or Print) Hulda Bizlawski

2. DATE OF DEATH July 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore — Yrs. 13 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3107 Brezehill Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	W	Married	Aug. 18, 1920	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Johnstown, Pa.	USA.

13. FATHER'S NAME Joseph P. Miller 219-16-4542

14. MOTHER'S MAIDEN NAME Bertha Gowecknour

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT Chester Bizlawski ADDRESS 3107 Greenhill Ave Baltimore 17, Md.

MEDICAL CERTIFICATION

(Effect age is especially important. Physician: please write clearly.)

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary Infarction, Rt. base - 6 days
Chronic Passive Congestion

DUE TO

(B) Mitral Stenosis + Aortic Valve Involvement

DUE TO

(C) Rheumatic Heart Disease — 21 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 30, 1949 *to* July 10, 1949 *that I last saw the deceased alive on* July 10, 1949, *and that death occurred at* 11:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph H. LiPuma M. D.	Mercy Hospital	July 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 14-1949	Sacred Heart of Mary	Baltimore Co Md

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE — 25. FUNERAL DIRECTOR — ADDRESS

JUL 11 1949 — Huntington Williams, M.D. — George A. Weber

VS 150

92 B

ed by Md. Ex.

G76192

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

G76192

Registered No.

1. NAME OF DECEASED (Type or Print): John GASPAROVIC

2. DATE OF DEATH: 7-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 813 N. Rose St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	married	July 8, 1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor	Lebow Bros.	Czechoslovakia	

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT — ADDRESS: Walter Gasparovic-son-3105 Juneau Pl.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive Cerebral Hemorrhage
DUE TO
(B) Hypertension and Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/7, 1949 *to* 7/7, 1949 *that I last saw the deceased alive on* 7/7, 1949, *and that death occurred at* 5:25 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Bernard Popper M. D. | 23B. ADDRESS: Sinai Hospital | 23C. DATE SIGNED: 7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/12/49	Oak Hill Cemetery	Horner's Lane, Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUL 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

83a

correct age is especially important. Please write

G76193

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76193

1. NAME OF DECEASED (Type or Print): VIGLIATO, Paul

2. DATE OF DEATH: 7-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
D. STREET ADDRESS (If rural, give location): 1546 N. Gay ST. 8-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Jan 27, 1892	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber		ITALY	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Joseph L. Vigliato (son) ADDRESS: 1546 N. Gay Stree

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) UREMIA
DUE TO
(B) Hypertensive, Cardio-vasc
DUE TO
(C) Hypertensive Renal Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/12/49, 19__, *to* 7/9/49, 19__, *that I last saw the deceased alive on* 7/9/49, 19__, *and that death occurred at* 2:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William H. Rodgers M. D.	St. Joseph's Hospital	7/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/13/49	Holy Redeemer Cemetery	4430 Belair Rd. Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 11 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-5 E. Madison St.

VS 150

Correct age is especially important. Physician, please

131a

G76194

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43

Registered No. G76194

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK NOBLE

2. DATE OF DEATH July 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 939 Linden Avenue 11-04

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 8 1901
9. AGE (In years last birthday): 48
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel worker
10B. KIND OF BUSINESS OR INDUSTRY: Steel
11. BIRTHPLACE (State or foreign country): Franklin, N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Noble
14. MOTHER'S MAIDEN NAME: Bessie Blackner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-07-0170
17. INFORMANT: Mrs. Carrie J. Noble ADDRESS 939 Linden Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypertensive Cardio-Vascular Disease	
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED July 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE 7/13/49
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn
24D. LOCATION (City, town, or county) (State) Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Holland Funeral Home
ADDRESS 1631 (931) Druid Hill Ave

VS 151

Please write the cause of death in ink. Physician: please write the exact age in especially important.

G76195

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

590

G76195

Registered No.

1. NAME OF DECEASED (Type or Print): MARY AUGUSTUS JOHNSON

2. DATE OF DEATH: 7/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1050 Vine St
C. Length of stay in Baltimore: 50yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1050 Vine St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Widowed	5/15/1883	66	1 / 21	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Eastern Shore, Md
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Jacob Augustus
14. MOTHER'S MAIDEN NAME: Caroline
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Gertrude Brown(D) ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Glomerulonephritis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1949 *to* July 6, 1949 *that I last saw the deceased alive on* July 5, 1949 *and that death occurred at* 9.40 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1612 Edmondson Ave
23C. DATE SIGNED: 7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/9/49	Mt. Auburn Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles G. Cooper
ADDRESS: 512 Carrollton Av.

VS 150

130

G76196
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

570 5 G76196
Registered No.

1. NAME OF DECEASED (Type or Print): Laverne Womack
2. DATE OF DEATH: July 11 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: St. Mary's
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lexington Park
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	10-6-10	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waitress		Penn.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Howard Edgin	Lillie White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Liver Abscess & Septicemia — Interval between onset and death: 2 wks
DUE TO
(B) Intestinal Obstruction — 1 wks
DUE TO
(C) Adherions — 14 yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June 17, 1949	Adhesions & obstruction	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	JOHNS HOPKINS HOSPITAL

22. *I hereby certify that I attended the deceased from* June 7 1949 *to* July 11, 1949 *that I last saw the deceased alive on* July 11, 1949 *and that death occurred at* 7:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. C. Burdeman M. D.	John Hopkins Hosp	July 11 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/11/49		Penn.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams, M.D.	C. B. Robinson	Leonardtown Md.

VS 150

1226

G76197

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

81 G76197 Registered No.

1. NAME OF DECEASED (Type or Print): Mary Dailey Sherwood

2. DATE OF DEATH: July-10-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 118 E. 24th. Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at Home

c. Length of stay in Baltimore: 53 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 118 E. 24th. Street

1x 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	If under 1 month: Days	If under 24 hours: Hours	Min.
Female	White	Single	Sept-9-1873	75 years				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Teacher	Teacher	Queenstown, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Not Known	Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	None	James Blair,	118 E. 24th. Street, Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Carcinoma of Bladder — 2 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 30, 1948 *to* July 9, 1949, *that I last saw the deceased alive on* July 9, 1949, *and that death occurred at* 2 00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Arthur J Davies M. D.	800 E 33rd St.	7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July-12-1949	Chesterfield Cemetery	Centreville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
	[illegible] M.D.	Stewart & Mowen Co.,	108 W. North Avenue Baltimore #1, Md.

VS 150

JUL 11 1949

52B

Correct age in capsule. Important. Physician: please write plainly.

G76198

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-0.1

G76198

Registered No.

1. NAME OF DECEASED (Type or Print) Rudolph Bernhart Stehl

2. DATE OF DEATH July 7/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3904 Maine Ave

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE COUNTY 3904 Maine Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Maryland

D. STREET ADDRESS (If rural, give location) 3904 Maine Ave 15-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	Feb. 24 1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Bernhart G. Stehl

14. MOTHER'S MAIDEN NAME Mary J. Reigart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Anna Marie Stehl ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Occlusion

DUE TO

(B) Atherosclerotic C-V Disease c Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 7, 1949 *to* July 7, 1949 *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE Chas. E. Cator Jr. M.D. M. D.

23B. ADDRESS 6007 York Road

23C. DATE SIGNED 7/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) July 11-49

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY Loudon Park

24D. LOCATION (City, town, or county) Balto (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Ellsworth Armacost

ADDRESS 5116 Harford Rd

937

VS 150

Cause of death is especial importance. Physician must write in full.

G76199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ Do not Release

541.0

G76199

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Norma Bethea

2. DATE OF DEATH: 7-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp

C. Length of stay in Baltimore: 48 Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2647 Huron Street 25-33

5. SEX: M.
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 1-29-01
9. AGE (In years last birthday): 48
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY: Private
11. BIRTHPLACE (State or foreign country): S. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Alice Bethea ADDRESS: 2647 Huron St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Probable Ventricular fibrillation due to
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hemorrhage from Duodenal Ulcer.
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 7-8-49
19B. MAJOR FINDINGS OF OPERATION: Bleeding Duodenal Ulcer
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-4, 1949, *to* 7-8, 1949, *that I last saw the deceased alive on* 7-8, 19___, *and that death occurred at* 7½ p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. G. Smith Jr. M. D.
23B. ADDRESS: Univ. Hosp
23C. DATE SIGNED: 7-8

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 11/49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Dillon S. C.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 7 1949
REGISTRAR'S SIGNATURE: Kenneth [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Gobb. G. Elliott & Daughter
ADDRESS: 1170 1129 N. Carolina St.

G76200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 916.0

Registered No. G76200

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN HARVEY PUGH N-948. 2. DATE OF DEATH July 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Virginia B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give towaship) Charlottesville
D. STREET ADDRESS (If rural, give location) 921 6th Street South East

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	W Single	Jan. 5, 1942	7 smt		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Charlottesville, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Early Pugh

14. MOTHER'S MAIDEN NAME Edith Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Early Pugh ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Third degree burns of 100% of body	
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 321 E. 20th Street 12/4

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 11, 1949 ? A m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? House afire

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE C. L. Gubinske M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	July 11, 1949	Riverview, Cemetery	Charlottesville, Va.

DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR ADDRESS Wm. Cook Inc.. 1217 St. Paul St.

VS 151

180

Correct age is especially important. Physician please write plainly.

G76201 ✓ E 916.0 G76201

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MAGGIE PUGH N-948 ✓

2. DATE OF DEATH: July 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Charlottesville
D. STREET ADDRESS (If rural, give location): 921 6th Street South East

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 23, 1892
9. AGE (In years last birthday): 56
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Batesville, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S. A.

13. FATHER'S NAME: Edgar J. Clark
14. MOTHER'S MAIDEN NAME: J. M. Bishop

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Early Pugh
ADDRESS:

MEDICAL CERTIFICATION

Cause age is especially important. Physician: please write clearly and fully.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Third degree burns of 100% of body
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 321 E. 20th Street 12/4
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 11, 1949 ?A.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? House afire

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: D. L. Tabscott M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: July 11. 1949
24C. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
24D. LOCATION (City, town, or county) (State): Charlottesville, Va.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 11 1949
REGISTRAR'S SIGNATURE: Tuntington Williams, MD
25. FUNERAL DIRECTOR: Wm. Cook Inc.
ADDRESS: 1217 St. Paul St.

VS 151

180

G76202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76202 Registered No.

STATE NO. G76202

1. NAME OF DECEASED (Type or Print) Jacob Saffran

2. DATE OF DEATH July 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 S. Pulaski St.

C. Length of stay in Baltimore — Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-04
D. STREET ADDRESS (If rural, give location) 48 S. Pulaski St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Married	May 19 1872	77	1	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman
10B. KIND OF BUSINESS OR INDUSTRY Balto. City.
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME George Saffran
14. MOTHER'S MAIDEN NAME Un Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT Mary Saffran ADDRESS 48 S. Pulaski St.

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic C.V. disease	
	DUE TO	
	(B)	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

MEDICAL CERTIFICATION

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1949 to July 9, 1949, *that I last saw the deceased alive on* July 1, 1949, *and that death occurred at* 6:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE C. L. Schwab M. D.
23B. ADDRESS 1546 W Baltimore
23C. DATE SIGNED 7/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-12-49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1949
REGISTRAR'S SIGNATURE Countersigned for Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Geo. L. Schwab 2101 Frederick Ave

VS 150

93D

G76203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

916 G76203 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOAN KENNEDY N-941 2. DATE OF DEATH July 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 321 E. 20th Street 12-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Female	White	Single	Oct. 29, 1934	14				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Charlottesville, Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George A. Kennedy.
14. MOTHER'S MAIDEN NAME Florence Pugh.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) First, second, and third degree burns of 85% of body DUE TO
(B) DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 321 E. 20th Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 11, 1949 ? Am.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? House afire

22. *I certify that I took charge of the remains described above, held an* Inspl & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE C. L. Turbush M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	July 14 1949	Riverview Cemetery	Charlottesville, Va.

DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1949
REGISTRAR'S SIGNATURE Thurston Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Wm Cook Inc. 1217 E. Paul St.

180

E916.0 G76204

BIRTH NO. G76204

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): PEGGY KENNEDY N-948 r

2. DATE OF DEATH: July 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 321 E. 20th Street 1r-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year Months	Days	If under 24 Hours Hours	Min.
Female	White	Single	Dec. 24, 1936	12				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Charlottesville, Va	U.S.A.

13. FATHER'S NAME: George A. Kennedy

14. MOTHER'S MAIDEN NAME: Florence Pugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Third degree burns of 90% of body
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	321 E. 20th Street

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 11, 1949 ?A m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	House afire

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
C. J. Sulinski M.D.		7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	July 11, 1949	Riverview Cemetery	Charlottesville, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams, MD	Wm. Cook Inc.	1217 E. Paul St.

180

Please write the cause of death clearly and legibly. Physician: please be especially careful that age is correct.

G76205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76205

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Gregory

2. DATE OF DEATH July 9th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1135 W. Franklin St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 15yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1135 W. Franklin St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Widowed	March 10 1859	90				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Housework	Oxford, N.C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Cruse	Agnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	None	Isaac Gregory	317 N. Gilmor St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Intern-selenitis P.U.	
ANTECEDENT CAUSES	DUE TO (B) Prima	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
M.D.		9 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	5/13/49	Michael Creek Cem.	Oxford, N.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 11 1949	Huntington Williams, M.D.	Charles G. Cooper	512 Carrollton Av.

931

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

76206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

002

G76206

BIRTH NO.

Registered No. G 76206

1. NAME OF DECEASED (Type or Print) Paul T. Buckler

2. DATE OF DEATH July 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland Penitentiary 954 Forrest Street

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 50 East Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	11-4-1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) St. Mary's Co., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James R. Buckler

14. MOTHER'S MAIDEN NAME Mary Cusack

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Mental defective

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-28-1949 *to* 7-8- , 1949 *that I last saw the deceased alive on* 7-6- , 1949 *and that death occurred at* 4:25P *m., from the causes and on the date stated above.*

23A. SIGNATURE Henry W. D. Hilgis M. D.

23B. ADDRESS

23C. DATE SIGNED 7-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-12-49	Glen Haven	A.A.Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR 7-12-49

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Wm Cook, Inc.-1217 St.Paul St.

VS 150

13-13

G76207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76207

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Zolk, Mary

2. DATE OF DEATH 7-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1210 N. Wolfe Street 8 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Married	2-18-72	77 76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House w. Fa
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Frederick Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Eugene Howard
14. MOTHER'S MAIDEN NAME Mary Knolls

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT J. Leroy Zolk ADDRESS 1210 N. Wolfe St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Coronary Insufficiency
DUE TO
(C) Coronary Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-9-49 *to* 7-10, 1949 *that I last saw the deceased alive on* 7-10, 1949 *and that death occurred at* 8 P m., *from the causes and on the date stated above.*

23A. SIGNATURE George W. Bokovic M. D.
23B. ADDRESS Franklin Sq. Hosp
23C. DATE SIGNED 7-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/13/49
24C. NAME OF CEMETERY OR CREMATORY Green Mount
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 12 1949
REGISTRAR'S SIGNATURE Thurston for Williams, M.D.
25. FUNERAL DIRECTOR Wilhelm Co Inc
ADDRESS 127 St Paul St

VS 150

940

G76208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76208

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NORMAN REESE

2. DATE OF DEATH July 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Mercy Hospital

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1814 North Charles Street 12-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Single	about May 28th 1892	57 59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Reporter	News Paper	N.Y.	

13. FATHER'S NAME: Geo. Reese

14. MOTHER'S MAIDEN NAME: Julia (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown	Unknown	Mrs. Foster	712 S. Paul St

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic alcoholism	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Shock, Multiple injuries, Acute psychosis (mp)	

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) police station	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Central District Station, Fayette & Fallsway
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY July 4, 1949 m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21F. HOW DID INJURY OCCUR? Injured while throwing self about cell

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
William J. McCafferty M.D.		July 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	7/22/49	Greenmount	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	Thurlington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 151

77

G76209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Vol. 1

Registered No. G76209

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Louis Rudolph

2. DATE OF DEATH July 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4807 Laurel Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 45 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4807 Laurel Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	July 15, 1881	67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tavern Business

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Unkown

14. MOTHER'S MAIDEN NAME Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Philip Rudolph ADDRESS 4807 Laurel Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — (INTERVAL BETWEEN ONSET AND DEATH) 5 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — 10 years?

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1948 *to* 7/11 1949, *that I last saw the deceased alive on* 7/11 1949, *and that death occurred at* 1145 m., *from the causes and on the date stated above.*

23A. SIGNATURE Sol Smith M. D.

23B. ADDRESS 1223 E North Ave

23C. DATE SIGNED 7/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 12, 1949

24C. NAME OF CEMETERY OR CREMATORY Southern Ave Cem

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 12 1949

REGISTRAR'S SIGNATURE Tomlinson Williams, M.D.

25. FUNERAL DIRECTOR Sol Levinson & Bros

ADDRESS 1126 W North Ave

94a

VS 150

Please write the cause of death clearly and legibly. Physician: please write cause of death clearly and legibly. Cohet age is especially important.

G76210

BC 49-13676

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

776

Registered No. G76210

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BABY GIRL FURST

2. DATE OF DEATH 7-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOCTORS' HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) 5224 Ready Ave. 27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F.	WHITE	NEW BORN	7-3-49					1

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME WILLIAM WALLACE FURST

14. MOTHER'S MAIDEN NAME HERMINA JOHANNA RUHL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

(Please write plainly. Physician: please state exact age is especially important.)

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

ANTECEDENT CAUSES

(B)

II. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-3-49, 19__, *to* 7-3, 19 49 *that I last saw the deceased alive on* 7-3-, 1949, *and that death occurred at* 8:54 A *m., from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.

23B. ADDRESS 2230 N Chas St

23C. DATE SIGNED 7/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY JOHN HOPKINS MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 12 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

JUL 10 1949 Commissioner of Health

VS 150

159

G76211

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 0 0 G76211

Registered No.

1. NAME OF DECEASED (Type or Print) MARY F. SKINNER

2. DATE OF DEATH July 10, 1949

3. PLACE OF DEATH: Baltimore City, Maryland 1629 Poplar Grove St.

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1629 Poplar Grove St. 15-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	Married	Dec. 16, 1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home	Home	Baltimore, Md.	USA

13. FATHER'S NAME: Samuel Striewig

14. MOTHER'S MAIDEN NAME: Sabilla Mark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Mr. Charles A. Skinner	1629 Poplar Grove St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(B) Arteriosclerosis, Generalized — 2½ yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 6, 1949, *to* July 10, 1949, *that I last saw the deceased alive on* July 10, 1949 *and that death occurred at* 2 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C Bradley Daugherty M. D.	3033 W. North Ave	July 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/12/49	Loudon Park Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	Curtis Fox Williams, M.D.	Wm. J. TICKNER & SONS, INC.	NORTH & PENNA. AVES. BALTIMORE-17, MD.

VS 150

97

Please write the cause of death clearly and correct age is especially important. Physician:

BIRTH NO. 76212

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76212

1. NAME OF DECEASED (Type or Print): Mauldin, Harry MAULDIN
2. DATE OF DEATH: 7/11/49
3. PLACE OF DEATH: Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: MD. COUNTY: Balto.
   C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
   D. STREET ADDRESS (If rural, give location): 2825 Monte Bello Terrace
6. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
   c. Length of stay in Baltimore: Yrs. Mos. Days
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: June 8, 1902
9. AGE (In years last birthday): 47 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK
10B. KIND OF BUSINESS OR INDUSTRY: Municipal
11. BIRTHPLACE (State or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Harry L. Mauldin
14. MOTHER'S MAIDEN NAME: Sarah O. Mallick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 700-03-6625
17. INFORMANT: Mr. Harry B. Mauldin ADDRESS: 2825 Montebello Terrace

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Infarction of myocardium — INTERVAL BETWEEN ONSET AND DEATH: 15 days

DUE TO

(B) Arteriosclerotic Heart Disease years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-26, 1949, to 7-11, 1949, *that I last saw the deceased alive on* 7-11, 1949, *and that death occurred at* 2.45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. J. Latham M. D.
23B. ADDRESS: Franklin Sq Hospital
23C. DATE SIGNED: 7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/13/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS, ADDRESS: NORTH & PENNA. AVES. BALTIMORE-17, MD.

VS 150

937

Please write the cause of death clearly and legibly. Physician: please specify important.

G76213 120676

CERTIFICATE CORRECTED 8-26-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76213

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Christo Stakias

2. DATE OF DEATH July 10- 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

b. Length of stay in Baltimore 33 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 901 Broadway 7-04

5. SEX M
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Dec. 25-1888
9. AGE (In years last birthday) 61 60 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker
10B. KIND OF BUSINESS OR INDUSTRY Williams P Stakias
11. BIRTHPLACE (State or foreign country) Greece
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ? (D) Emanuel
14. MOTHER'S MAIDEN NAME ? (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Records Baltimore City Hospitals ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6- 23- , 1948 *to* 7- 10- , 1949, *that I last saw the deceased alive on* 7- 10- 1949, *and that death occurred at* 2.45Am., *from the causes and on the date stated above.*

23A. SIGNATURE C.S. Logas M. D.
23B. ADDRESS B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED 7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 12-49
24C. NAME OF CEMETERY OR CREMATORY Greek Cemetery
24D. LOCATION (City, town, or county) (State) Windsor Mill Rd

DATE RECEIVED BY LOCAL REGISTRAR JUL 12 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Lambros Inc ADDRESS 440-E. North ave

VS 150

61

G76214 — 109260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

143 — Registered No. G76214

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Crews

2. DATE OF DEATH: July 2-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1325 Edmondson Ave. 19-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Negro	Single	July 23- 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Harwell or Howell
14. MOTHER'S MAIDEN NAME: Cathyrene or Catherine Taylor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals Records- 4940 Eastern Ave. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular Accident
DUE TO
(B) Hypertensive Arteriosclerosis Cardio Vascular Disease.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hyperthyroidism

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ No ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-18- , 1947 *to* 7-2- , 1949, *that I last saw the deceased alive on* 7-2- , 1949 *and that death occurred at* 8.45am, *from the causes and on the date stated above.*

23A. SIGNATURE: H. S. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): JUL 12 1949

DATE RECEIVED BY LOCAL REGISTRAR: JUL 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

JUL 12 1949

63B

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76215 JL - 129138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1-4-1 G76215

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Gartside

2. DATE OF DEATH 7-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 8 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1504 E. Lafayette Ave. 8-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	June 29, 1[illegible]	8[illegible]		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry C. Gartside	Emma Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		B. C. H. Records,	4940 Eastern Ave.

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma Of Parotid Gland- Right Side
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Terminal Pneumonia
Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-2-49	Biopsy of Neck Mass	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-21-49, 19__, *to* July 5, 1949 *that I last saw the deceased alive on* July 5 1949, *and that death occurred at* 8.30 PM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. B. Lozier M. D.	4940 Eastern Ave.	7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		[illegible] UNIVERSITY MEDICAL SCHOOL	JUL 12 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	Washington Williams, M.D.	Commissioner of Health	

VS 150

55E

6216
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

G76216
Registered No.

1. NAME OF DECEASED (Type or Print) SARAH S HOOD

2. DATE OF DEATH July 10 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 721 Field St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 721 Field St. 13-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed.	April 24 1860	89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	—	Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Peter Wolf.	Mary E. Short

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
—	—	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO

(B) Arterio sclerosis — 20 years

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 3, 1949 *to* July 10, 1949, *that I last saw the deceased alive on* July 10, 1949, *and that death occurred at* 5 am *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathan Brown M. D.	800 W 33rd St.	7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 13 1949	St Mary's	Hampden.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	Huntington Williams, M.D.	Paul E Shemanski Jr	3615-17 Chestnut Ave.

VS 150

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

83a

G76217 - N - 8P13 X 20 4.0 G76217

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 7/10/49

1. NAME OF DECEASED (Type or Print) Mrs. EUGENIA C. HUBBARD

2. DATE OF DEATH [redacted] 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home Hospital

c. Length of stay in Baltimore Yrs. Ten Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTO.
C. CITY OR TOWN Towson (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 231 Ridge Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	M	Oct. 16 1915	33		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Virginia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Eugene Coiner	Bess Fair

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			Joseph Hubbard	Same

MEDICAL CERTIFICATION

(Please write the cause of death clearly and accurately. Physician: please note that age is especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Lymphatic Leukemia — INTERVAL BETWEEN ONSET AND DEATH 6 Mos.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-16, 1949 *to* 7/10, 1949 *that I last saw the deceased alive on* 7/10, 1949 *and that death occurred at* 12 N *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert E. Lyon M. D.	Church Home Hosp.	7/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	7-13-49	Maryland Park	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	Huntington Williams, M.D.	Leonard J. Luck	5305 Harford Rd.

VS 150

74a

G76218

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76218

1. NAME OF DECEASED (Type or Print) Gertrude Schmidt

2. DATE OF DEATH July 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

C. Length of stay in Baltimore 50 4/3. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural #21 ESSEX
D. STREET ADDRESS (If rural, give location) Mace and Essex Avenues

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married	11-25-1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Germany	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Husband Conrad Schmidt ADDRESS as above

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial failure — pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 3-4 hrs

DUE TO

(B) aortic stenosis — over 8 years

DUE TO

(C) Hypertensive arteriosclerotic Cardiovascular disease / Nephrosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7-10, 1949 *to* 7-10, 1949 *that I last saw the deceased alive on* 7-10, 1949, *and that death occurred at* 11 3/4 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marguerite Louise Cadle M. D.	Maryland General Hospital	7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-13-49	Moreland Park	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	[redacted] Millsboro, Md	Leonard Peuke - 5305	Harford Rd

VS 150

131a

Please write the cause of death clearly and legibly. Physician's special attention is especially important. Physician's please write the correct age is especially important.

G76219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76219

BIRTH NO. | Registered No.

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

1. NAME OF DECEASED (Type or Print): AARON TAYLOR | 2. DATE OF DEATH: 7-10-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 611 W. HOFFMAN STREET
C. Length of stay in Baltimore: 35 YRS. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 1. 17-04
D. STREET ADDRESS (If rural, give location): 611 W. HOFFMAN ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
MALE	COLORED	WIDOWED	? 1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER		MARYLAND	U.S.A.

13. FATHER'S NAME: HENRY TAYLOR
14. MOTHER'S MAIDEN NAME: JANE WILLIAMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: MRS. GEORGIA TAYLOR - 114 MECHANIC ST CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: July 4 - July 10
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 4 *1949, to* July 10 *1949, that I last saw the deceased alive on* July 9 *1949, and that death occurred at* 6 4 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. Garland Schimell M. D.	1534 Druid Hill Ave	July 12 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
REMOVAL	7-12-49.	SUMMIT	CUMBERLAND, MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 12 1949	Washington Williams, M.D.	Wm. A. JACKSON - 916 PENNA. AVE.

VS 150

94a

G76220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

481

Registered No. G76220

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Florence Hawkins Foster

2. DATE OF DEATH July 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 707 N. Carrollton Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 707 N. Carrollton Ave

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 707 N. Carrollton Ave 16-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	Colored	Widow	Nov. 19, 1889	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Hawkins

14. MOTHER'S MAIDEN NAME Margaret H. Winder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Lillian Gibbs ADDRESS 707 N. Carrollton Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Occlusion	several hrs.
	DUE TO (B) Influenza	several wks
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 27, 1949, to July 10, 1949, *that I last saw the deceased alive on* July 9, 1949, *and that death occurred at* 6:45P m., *from the causes and on the date stated above.*

23A. SIGNATURE Richard H. Hurst M. D. | 23B. ADDRESS 1631 W. Franklin St. | 23C. DATE SIGNED 7-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7/14/49 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. | 24D. LOCATION (City, town, or county) (State) Longgreen, Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 12 1949 | REGISTRAR'S SIGNATURE [redacted] | 25. FUNERAL DIRECTOR ADDRESS Mrs Frances A Hensley 578 W. Baltimore St

VS 150

94a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

76221

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76221

Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES - A. COLE.

2. DATE OF DEATH: July-10-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital.

c. Length of stay in Baltimore: 40 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 408 - N. Monroe St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married.	April-7-1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Machinist.	U.S. Navy Yard.	Indiana.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel J. Cole.	Jennie Bowman.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
Yes. U.S. Navy-1908 to 1911.		Mrs. Annie M. Cole, - 408 N. Monroe St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute cardiac dilatation — Interval between onset and death: Immed.

DUE TO

(B) Cardio - vascular disease — 3 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1 1949 *to* July 10 1949 *that I last saw the deceased alive on* July 10, 1949 *and that death occurred at* 5:32 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Homer L. Todd M. D.	2108 St Paul St	7/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial.	July-13/49.	Druid Ridge Cemetery.	Pikesville, - Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	Huntington Williams, M.D.	Charles J. Schwab	3572 Frederick Ave.

VS 150

937

Please write the cause of death clearly and correct age is especially important. Physician:

076222

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 076222

1. NAME OF DECEASED (Type or Print): Alexander Irby

2. DATE OF DEATH: 7-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt.
D. STREET ADDRESS (If rural, give location): 615 Conway St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	MARRIED	Jan. 15, 1912	37		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Spartanburg, S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William Irby
14. MOTHER'S MAIDEN NAME: Nellie Anderson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Irby. ADDRESS: 615 W. Conway St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Resp. Paralysis
DUE TO
(B) Sub-Arachnoid Hemorrhage
DUE TO
(C) Hypertension & Bronchitis
Rupt. Aneurysm (carotid)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1949, *to* July 9, 1949, *that I last saw the deceased alive on* July 9, 1949, *and that death occurred at* 12:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: T. G. Brooks Jr. M. D.
23B. ADDRESS: Univ. Hosp.
23C. DATE SIGNED: 7-9

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-12-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Am.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Wm. Luke R. Williams
ADDRESS: 322 W. Lafayette Ave

VS 150

96

Please write the cause of death clearly and legibly. Physician: please write the correct age if especially important.

G76223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G76223

1. NAME OF DECEASED (Type or Print) Herman Smith

2. DATE OF DEATH July 9, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 600 N. Carrollton Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 600 N. Carrollton Ave

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 600 N. Carrollton Ave
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 600 N. Carrollton Ave. 16-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	C	married	March 1903	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Taylorsville, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Perry Smith.

14. MOTHER'S MAIDEN NAME Louise Boyde.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Amelia Smith ADDRESS 600 N. Carrollton Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hemorrhage due to carcinoma of	
	DUE TO esophagus	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
II	(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl Ryder M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED July 19 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-13-49	Mt. Zion Cem.	Lansdowne Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 12 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

FUNERAL DIRECTOR Wm. Lake Williams ADDRESS 3227 Sherwood Ave

VS 151

46a

G76224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

OO V

Registered No. G76224

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert Hawkins

2. DATE OF DEATH: 2/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1126 Parrish St

C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 1126 Parrish St 16-04

5. SEX: C
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 1901
9. AGE (In years last birthday): 47
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benson Hawkins
14. MOTHER'S MAIDEN NAME: Alice Watkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 217-09-8221
17. INFORMANT: Irene Hawkins ADDRESS: 1126 Parrish St

MEDICAL CERTIFICATION

Please write plainly, using ink. Do not use abbreviations. Enter only one cause per line for (a), (b), and (c). For deaths due to injuries, describe the accident, giving date of occurrence. Report only the disease or condition directly causing death or conditions resulting in death. Operations should be reported only if performed for conditions contributing to death. Enter the cause of death clearly and legibly. Physician: please write the exact age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Hypostatic Pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Far advanced pulmonary tuberculosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: P. S. Sulinski M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED: 2/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 7/14/49

24C. NAME OF CEMETERY OR CREMATORY: Arbutus

24D. LOCATION (City, town, or county) (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 12 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Geo. H. Kelson ADDRESS: 1303 Fountain St

VS 151

13D

G76225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

41 D

G76225

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Annette Catherine Schoepflin

2. DATE OF DEATH: July 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 502 S. Macon Street 26-07

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 4/15/1908
9. AGE (In years last birthday): 41 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wife.
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Poetzel
14. MOTHER'S MAIDEN NAME: Catherina Bookhage

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Henry Schoepflin ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic heart disease
DUE TO
(B) & Mitral stenosis & renal infarction
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 6/17/ , 1949, to 7/11/49 *that I last saw the deceased alive on* 7/11/ , 1949 *and that death occurred at* 11:12 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE: A. Cantwell Allen, M. D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: 7/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/15/49
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart
24D. LOCATION (City, Town, or County) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 12 1949
REGISTRAR'S SIGNATURE: Torrington Williams, M.D.
25. FUNERAL DIRECTOR: Kelly & Lee Inc.
ADDRESS: 1128 S. Wolfe

VS 150

92 B

Write the cause of death clearly and correct age is especially important. Physician: please write

G76226

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 r 1

G76226

Registered No.

1. NAME OF DECEASED (Type or Print) Mary Frances Lentz

2. DATE OF DEATH 7/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1131 Williams St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1131 Williams St Dalls Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 24-03
D. STREET ADDRESS (If rural, give location) 1131 Williams St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	N	Widow	9/25/1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	—	Dalls Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Bernard Freesmonth	Thurman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Miss Lydia Lentz

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO
(B) Generalized lymphadenopathy etiology undetermined — 6 Mo.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(Lymphadenopathy)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 19 49 *to* July 10 19 49 *that I last saw the deceased alive on* July 9 19 49 *and that death occurred at* 3:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. G. Gilliam M. D.	107 E. West St.	7/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/13/49	Holly Grove & Co.	Ruckle Highway

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	Washington Williams, M.D.	J. J. Daley Sons	316 Light St

VS 150

931

Please write the cause of death clearly and accurately. Physician: please write the exact age if especially important.

G76227 Buehner ✓ 1 G76227

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print)	Catherine Beehner
2. DATE OF DEATH	7/10/49
3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	John Hopkins Hospital
C. Length of stay in Baltimore	1 Yrs. 7 Mos. 0 Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Md.
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore Md
D. STREET ADDRESS (If rural, give location)	402 N. Castle St 6-04
5. SEX	F
6. COLOR OR RACE	W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH	June 13, 1876
9. AGE (In years last birthday) / If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.	73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	None
10B. KIND OF BUSINESS OR INDUSTRY	— —
11. BIRTHPLACE (State or foreign country)	Baltimore
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	— Winkel
14. MOTHER'S MAIDEN NAME	Elizabeth
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) / (If yes, give war or dates of service)	—
16. SOCIAL SECURITY NO.	—
17. INFORMANT / ADDRESS	Bernard Buehner, N. Castle St 407

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic C.V disease	
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑
21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	P. J. Lubinski M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED	7/10/49	
24A. BURIAL, CREMATION, REMOVAL (Specify)	Burial	
24B. DATE	July 13/49	
24C. NAME OF CEMETERY OR CREMATORY	Trinity	
24D. LOCATION (City, town, or county) (State)	Baltimore	
DATE RECEIVED BY LOCAL REGISTRAR	JUL 12 1949	
REGISTRAR'S SIGNATURE	Lucretia Williams, Mgr	
25. FUNERAL DIRECTOR	Philip Henrichs Sons	
ADDRESS	2024 Eastern Ave	

931

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PLEASE WRITE PLAINLY, with ink, within the lines. Use no abbreviations. Be sure to state the cause of death clearly and legibly. Physician: please write the exact age in years, months, days, hours or minutes, as the case may be. Please answer all questions; if any are unimportant, please write "unknown" or "none" as the case may be.

BIRTH NO. G76228

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76228

1. NAME OF DECEASED (Type or Print): LOUIS NEWTON

2. DATE OF DEATH: July 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 927 W. Mulberry Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 927 W. Mulberry Street 18-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Single	Jan 8, 1910	39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Lee Co. S.C.	U.S.A.

13. FATHER'S NAME: Ramous Newton

14. MOTHER'S MAIDEN NAME: Mary Newton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Annie Clark	1738 Druid Hill Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute congestive heart failure
DUE TO
(B)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 14, 1949	Family lot	Lynchburg, S.C.

DATE RECEIVED LOCAL REG. JUL 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Holland Funeral Home, 1631 Druid Hill Ave.

VS 151

93E

G76229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76229

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Catherine M. Beary

2. DATE OF DEATH 7-10-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 719 Richwood Ave

c. Length of stay in Baltimore 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-10
D. STREET ADDRESS (If rural, give location) 719 Richwood Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	March 1868	81				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Ireland	

13. FATHER'S NAME Peter Curran

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Louise C. Beary ADDRESS 719 Richwood Ave

MEDICAL CERTIFICATION

Complete the cause of death clearly and correct age is especially important. Physician please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Hypostatitis — 6 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Generalized Arteriosclerosis — 1 Year

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral Hemorrhage — 6 mos

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1949 *to* July 10, 1949, *that I last saw the deceased alive on* July 9, 1949, *and that death occurred at* 2:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Thomas F. White M. D.

23B. ADDRESS 3809 Gwynn Oak Ave

23C. DATE SIGNED 7/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-13-49	Holy Redeemer	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	Huntington Williams, M.D.	John A. Moran	3000 E. Balt. St.

VS 150

937

G76230

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76230

1. NAME OF DECEASED (Type or Print) George H. Fenwick

2. DATE OF DEATH 7/11/1949

3. PLACE OF DEATH: X Baltimore City, Maryland Md.

A. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 238 St Mathew St.

B. Length of stay in Baltimore 30 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1238 St Mathew St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Col.	Married	Feb. 4, 1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		St Marys Co. Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Guy Fenwick	Francis Fenwick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		George S. Finwick	I238 St Mathew St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

DUE TO

(B) Cerebral Hemiplegia.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-20 1949 *to* 7-11, 1949, *that I last saw the deceased alive on* 9 July, 1949 *and that death occurred at* 2:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. C. Burwell M. D.	121 Aisquith St.	7/12/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 13, 1949	Mt Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	Tuttington Williams, M.D.	Elroy O. Wilson	1000 Brantly Ave.

VS 150

94a

Please write in ink and be sure that the cause of death clearly and correct age is especially important. Physician please write the

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 27623 B.C. 49-27998 E 9240 076231 Registered No.

1. NAME OF DECEASED (Type or Print): Gertrude English N-991

2. DATE OF DEATH: July 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: All Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1245 E. E. Eager St. 10-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C		12/25/48		6			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balto. Md.	U.S.A.

13. FATHER'S NAME: Charles English

14. MOTHER'S MAIDEN NAME: Julia Sawyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Julia English ADDRESS: 1245 E. Eager St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Mechanical Suffocation	
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	1245 E. E. Eager St.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 10, 1949 ? m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Face in pillow

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earle R Eager M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: June 11, 949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 13 1949	Mt Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	Turnbaugh Williams, M.D.	Elroy O. Wilson	1000 Brantly Ave

VS 151

182a

Please write plainly, with unfading ink. Every item should be answered. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

343

G76232

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES PURCELL

2. DATE OF DEATH July 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1013 E. Preston St. 10-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	5/1/23	26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Aircraft assembly	Glenn L. Martin	NC Winston Salem	USA

13. FATHER'S NAME: Charles T. Purcell

14. MOTHER'S MAIDEN NAME: Clara Myers,

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 2	Unknown	Records- US Marine Hospital	Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subacute transverse myelitis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/11/49	Slight fusiform swelling of cervical cord. ? Tumor.	YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 25, 1949, *to* July 12, 1949, *that I last saw the deceased alive on* July 12, 1949 *and that death occurred at* 12 midnight *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J.F. van Ackeren, M.D. Medical Director	US Marine Hospital, Balto, Md.	7/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/12/49	Woodland	Winston Salem N. C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	[illegible]	WM. J. TICKNER & SON INC.	North & Pa. Aves Balto. 17, Md.

VS 150

PLEASE WRITE PLAINLY, with ink or indelible pencil. Be sure the cause of death clearly and correct age is especially important. Physician: please write the

82

G76233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

154

G76233

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Albert Gontrum

2. DATE OF DEATH: July 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1020 N. Milton Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Aug. 19 1872	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sheet Metal Worker		Maryland	U.S.

13. FATHER'S NAME: William T. Gontrum

14. MOTHER'S MAIDEN NAME: Josephine Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown	215-05-7960	Mrs. Frances D. Gontrum	1020 N. Milton Ave

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Rectum — Interval between onset and death: 1 yr. 1 mo.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute Cardiac Failure — 4 hrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 7, 1949	Carcinoma of Rectum	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 6, 1949 *to* July 11, 1949 *that I last saw the deceased alive on* July 11, 1949, *and that death occurred at* 10:45 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John J. Pierpaolla M. D.	Mercy Hospital	July 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/15/49	Baltimore Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS, INC.	NORTH & PENNA. AVES. BALTIMORE-17, MD.

VS 150

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Entries must be complete and correct as to the cause of death clearly and correct age is especially important. Physician: please write the

467

CERTIFICATE CORRECTED 7-21-49

G76234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

199-8

Registered No. G76234

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Lisette A Roschen**

2. DATE OF DEATH **July 10 '49**

3. PLACE OF DEATH: A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Womens Hospital**

c. Length of stay in Baltimore **Life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **214 N. Fulton Ave.** 20-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year Months	Days	If under 24 Hours Hours	Min.
f	**W**	**Widowed**	**Oct. 8, ~~1880~~ 1879**	**68 69**				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balto. Md.	

13. FATHER'S NAME **Conrad Meinhardt**

14. MOTHER'S MAIDEN NAME **Louise Conrad**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr Hermann Roschen	**126 N Culver**

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH INK. Give the cause of death clearly and legibly. Physician please write the exact age in especially important.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Carcinoma, site undetermined** — INTERVAL BETWEEN ONSET AND DEATH: **5 mos.**

DUE TO **with bilateral pleural effusions.**

(B)

DUE TO

(C) **Hydronephrosis, right, due to urethral stricture.** — **-?**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* **April 4** 19**49**, *to* **July 10** 19**49**, *that I last saw the deceased alive on* **July 10** 19**49** *and that death occurred at* **11 P.** *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry F. Klinefelter. KLINEFELTER M. D.	**1601 St. Paul St.**	**7/12/49**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**July 14 '49**	**Loudon Park**	**Balto - Md**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	**Tunstall for Williams, M.D.**	**Harry H Wolfe**	**1111 Edmondson Ave**

HS 150

55E

G76235

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

473 G76235 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jack Kolson

2. DATE OF DEATH: 7/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (if not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: N.Y.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BROOKLYN
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	MARCH 6, 1918	31		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		NEWARK, N.J.	

13. FATHER'S NAME: MORRIS KOLSON

14. MOTHER'S MAIDEN NAME: JENNIE WALDMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		J.J. MORRIS INC.	BROOKLYN N.Y.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Enter the cause of death clearly and legibly. Physician: please write the exact age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 15 min

DUE TO
(B) Laryngeal Edema and Obstruction Thr — 2 days

DUE TO
(C) Debilitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/12/49	Emergency Tracheotomy	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/12 1949 *to* 7/12, 1949, *that I last saw the deceased alive on* 7/12 1949, *and that death occurred at* 3:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bernard Bogner M.D.	Sinai Hospital	7/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
REMOVAL	7/12/49	BROOKLYN	BROOKLYN N.Y.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 12 1949	Huntington Williams, M.D.	Wm Cook Inc	1217 St Paul St.

VS 150

115c

076236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 9160

Registered No. 076236

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY KIRTLEY N-948-V

2. DATE OF DEATH: July 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2122 N. Calvert Street 12-04

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: JUNE 22, 1926
9. AGE (In years last birthday): 23
If under 1 year: Months, Days
If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNEMPLOYED
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): W. VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES KIRTLEY
14. MOTHER'S MAIDEN NAME: BEATRICE BUCKLAND

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS BEATRICE KIRTLEY ADDRESS: STANFORD W.VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Second and third degree burns of entire body
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2122 N. Calvert Street 12/4
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 10, 1949 P m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? House afire

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 7-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE: 7/12/49
24C. NAME OF CEMETERY OR CREMATORY: STANFORD
24D. LOCATION (City, town, or county) (State): STANFORD. W. VA.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St Paul St

VS 151

180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if possible. Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

BIRTH NO. 76237 ac 49-13617

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54-7 G76237 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Loeschke

2. DATE OF DEATH: July 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctor's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 24
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5517 Plymouth Rd 27-06

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: July 10, 1949
9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours 7 | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Donald Brack Loeschke
14. MOTHER'S MAIDEN NAME: Naomi Margaret Spiekermann
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital Heart Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-10-49, 19 ; *to* 7-10-, 19 49 *that I last saw the deceased alive on* 7-10 19 49, *and that death occurred at* 5P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis J. Loeschke M. D.
23B. ADDRESS: 876 Worlington Rd
23C. DATE SIGNED: 7/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL JUL 12 1949
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JUL 12 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. ENTER ... correct age is especially important. Physicians: please write the cause of death clearly and legibly.

157E

675238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

675238 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alice L. Squires

2. DATE OF DEATH July 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1814 W. Baltimore St

C. Length of stay in Baltimore Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-01
D. STREET ADDRESS (If rural, give location) 1814 W. Baltimore St.

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH April 14, 1867
9. AGE (In years last birthday) 82
If Under 1 Year: Months 2, Days 27
If Under 24 Hours: Hours —, Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John O Squires
14. MOTHER'S MAIDEN NAME Mary M. O'Brien

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None.
17. INFORMANT Mrs. Frank Hooper ADDRESS 1814 W. Balto. St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Adeno-carcinoma of bladder — INTERVAL BETWEEN ONSET AND DEATH 2 yrs
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION April 1949
19B. MAJOR FINDINGS OF OPERATION As above
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1949, to July 11, 1949, *that I last saw the deceased alive on* July 11, 1949, *and that death occurred at* 1:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE John F. Coghlan M. D.
23B. ADDRESS 4201 Williams Ave
23C. DATE SIGNED 7/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-13-49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 12 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR ADDRESS Geo. L. Schwab 2101 Frederick Ave.

VS 150

52B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item is important. Physician: please write the cause of death clearly and correct age is especially important.

G75239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75239

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Stonewall Jackson Steiner 181

2. DATE OF DEATH 7/11/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Mercy Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

C. Length of stay in Baltimore Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 17 05
D. STREET ADDRESS (If rural, give location) 1807 Barclay Street

5. SEX male | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Nov. 17, 1884 | 9. AGE (In years last birthday) 64 | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor

10B. KIND OF BUSINESS OR INDUSTRY Grocery

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Levi Steiner

14. MOTHER'S MAIDEN NAME Mary Frances Douglas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Admission History

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute intestinal obstruction

DUE TO Volvulus of Caecum

(B) Secondary Anemia

DUE TO

(C) CA. of bladder excised Apr. 1999

INTERVAL BETWEEN ONSET AND DEATH: 3days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/11/49, 19__, to 7/11/49, 19__, *that I last saw the deceased alive on* 7/11, 1949, *and that death occurred at* 11:55 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Homer W. Mays M. D. | 23B. ADDRESS Mercy Hospital | 23C. DATE SIGNED 7/12/49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify) Burial | 24B. DATE 7/14/49 | 24C. NAME OF CEMETERY OR ~~CREMATORY~~ London Park | 24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 13 1949 | REGISTRAR'S SIGNATURE Huntington Williams M.D. | 25. FUNERAL DIRECTOR Wm. Bok Inc. ADDRESS 1217 St. Paul St.

VS 150 VIC

52B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and fully.

G76240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76240

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES WILLIAM SHAWN

2. DATE OF DEATH July 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Delaware
B. COUNTY New Castle
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wilmington
D. STREET ADDRESS (If rural, give location) 902 Haines Ave. Gordon Heights

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	September 6, 1897	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineering	Dupont Co.	Maryland	U.S.A.

13. FATHER'S NAME: William Shawn

14. MOTHER'S MAIDEN NAME: Laura J. Bishop

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: Mrs. Charles Shawn, 902 Haines Ave. Wilmington, Del.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute Pulmonary edema	
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
William G. Reluch M.D.		July 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	July 6, 1949	Denton Cemetery	Denton, Caroline, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 13 1949	Huddington for Williams M.D.	J. Virgil Emoore & Son, Denton, Md.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician should be correct age is especially important. Please write the cause of death clearly and legibly.

111 B

BIRTH NO. 76241

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No. 76241

1. NAME OF DECEASED (Type or Print): Katherine Vincent

2. DATE OF DEATH: July 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3616 N. Rogers Ave.
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3616 N. Rogers Ave. 48-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	June 14, 1878	71 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Bader	Margaret Woreline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No	None	Mrs. Carrie M. Hogue, 3616 N. Rogers Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute myocardial failure	3 days
DUE TO (B)	Dyspnea due arteriosclerotic cardiovascular disease	5 yrs.
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Arteriosclerosis	15 months

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* June 12, 1949, *to* July 11, 1949, *that I last saw the deceased alive on* July 11, 1949 *and that death occurred at* 11.55 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. Schlenger M. D.	4600 Liberty Heights Ave.	7/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 13, 1949	Baltimore National Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 13 1949	Huntington Williams, M.D.	Miles Lamotray	4510 Liberty Heights Ave.

VS 150

937

PLEASE WRITE PLAINLY, with unfading ink. Use typewriter if convenient. Do not abbreviate. Be sure to state the cause of death clearly and legibly. Physician: please write the correct age if especially important.

G76242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17 Registered No. G76242

BIRTH NO. 5242

1. NAME OF DECEASED (Type or Print): Max Siavitz

2. DATE OF DEATH: July 13 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3511 Woodbrook Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 57 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 3511 Woodbrook Ave. 13-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Feb. 15 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Russia	USA

13. FATHER'S NAME: Louis Siavitz

14. MOTHER'S MAIDEN NAME: Hannah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Minnie Siavitz	3511 Woodbrook Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of lung. — INTERVAL BETWEEN ONSET AND DEATH: about 2 yrs.

DUE TO

(B) metastases to long bones.

DUE TO

(C) Prostatic cac.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from ____, 1935 to July 13, 1949 that I last saw the deceased alive on July 12, 1949, and that death occurred at 2:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathan B. Shpritz M. D.	1810 Eutaw Pl.	7/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-13-49	Hebrew Young Mens	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 13 1949	Huntington Williams, M.D.	S. Levinson & Bros.	W North Ave. 1124-26

VS 150

47D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. Be correct age is especially important. Physician: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

44 ✓

Registered No. 675243

675243

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lucy Redd

2. DATE OF DEATH: July 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 130 Winter St. 23-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	married	Mar 14-1900	49 48	—	+	—	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Richmond Va
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Thornton
14. MOTHER'S MAIDEN NAME: Lucy Thornton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James Mankins ADDRESS: 130 Winter St

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypertensive C.V. Renal Disease	
	DUE TO (B)	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: M. L. Boyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 12 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 14 49	Mt. Calvary	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUL 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. A. Brooks ADDRESS: 1463 N. Carey St

VS 151

1310

G7S244

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

593 Registered No. G7S244

1. NAME OF DECEASED (Type or Print): Helena Walsh
2. DATE OF DEATH: July 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for the Aged
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St 10-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. If under 1 year, last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	W	Nov. 6, 1865	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Ireland	

13. FATHER'S NAME: William Walton
14. MOTHER'S MAIDEN NAME: Honora O'Neil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Sister Ignatius ADDRESS: 1200 Valley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Nephritis		1 yr.
DUE TO		
ANTECEDENT CAUSES		
(B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1949, to June 11, 1949, *that I last saw the deceased alive on* Jul 10, 1949, *and that death occurred at* 9, a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. F. Vogel Asst. Prof. M. D.	1823 N. Broadway	7/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 14, 1949	Cathedral	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
JUL 13 1949	Huntington Williams, M.D.	Peter Wiedefeld 900 E. Biddle St

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Correct age is especially important. Physician please write the cause of death clearly and legibly.

132

G76245 Werneth ✓ 1+ G76245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4+1

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Mary Werneth

2. DATE OF DEATH July 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home for the Aged

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1200 Valley St 10-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W.	S.	July 24/1849	99		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) 1849

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Lucas Werneth

14. MOTHER'S MAIDEN NAME Barbara Bunnelein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Sister Signature ADDRESS 1200 Valley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Valvular Heart Disease

DUE TO

(B)

DUE TO

(C) Old age.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 10, 1949 *to* July 11, 1949, *that I last saw the deceased alive on* July 10, 1949, *and that death occurred at* 8:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE Edmund Hall M. D.

23B. ADDRESS 1823 E. Fort Ave.

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 14/49

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 13 1949

REGISTRAR'S SIGNATURE Kensington Williamsport, Md

25. FUNERAL DIRECTOR Rita Friedfeld ADDRESS 900 E. Biddle St

VS 150

PLEASE WRITE PLAINLY, with INDELIBLE INK. Fill in all blanks. Be sure to state the cause of death clearly and legibly. Physician please write the correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 76246 — Registered No. 076246

1. NAME OF DECEASED (Type or Print): Nellie Mae Bond — 2. DATE OF DEATH: 7/10/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2429 Francis St.
C. Length of stay in Baltimore: 63 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE: Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-03
D. STREET ADDRESS (If rural, give location): 2429 Francis St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	In Law	May 27, 1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: George Butler
14. MOTHER'S MAIDEN NAME: Alberta Olney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	None	Avon L. Butler	2429 Francis St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aortic Insufficiency + Myocardial Insufficiency — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: ?

(B) Hypertension — DUE TO Arteriosclerosis + Nephritis. — ? 3 mos.

(C) Hemiplegia — 3 years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-1-, 1949 *to* 7-10, 1949 *that I last saw the deceased alive on* 7-10, 1949, *and that death occurred at* 11 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm S. Hamm, M. D.	2224 Madison Ave.	7-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/13/1949	Arbutus Mem. Pk.	Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 13 1949	Huntington Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the cause of death clearly and legibly. Physician: please write correct age is especially important.

131a

G76247

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76247

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Charles Frederick Ehrenfeld

2. DATE OF DEATH: 11 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital (DOA)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1656 Warwick Ave. 15-03

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Mar. 20, 1880
9. AGE (In years last birthday): 69 (If under 1 Year: Months / Days; If under 24 hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Perry Co. Pa.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John C. Ehrenfeld
14. MOTHER'S MAIDEN NAME: Mary E. Grissinger
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): None (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Mr. Alva W. Ehrenfeld ADDRESS: 1656 Warwick Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. N. Kamman, J. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 12 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/14/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Pk. Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS INC. ADDRESS: North & Pa. Balto. 17, Md.

VS 151

93D

BIRTH NO. 76248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Mary Benski

2. DATE OF DEATH: July 11-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1922 E. Fairmount Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1922 E. Fairmount Ave

6-04

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Not Known
9. AGE (In years last birthday): about 63
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Felix Cheson
14. MOTHER'S MAIDEN NAME: Katherine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Leo. Benski 1922 E. Fairmount Ave — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: INSTANT.

DUE TO
(B) CHRONIC AORTITIS — ???

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) ARTERIOSCLEROTIC, HYPERTENSIVE, CARDIO-VASCULAR DISEASE — SINCE 12/13/47

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 6 *, 19*49*, to* July 11 *, 19*49 *that I last saw the deceased alive on* July 11 *, 19*49 *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jos. F. Drenga M. D.
23B. ADDRESS: 209 S. Chester St
23C. DATE SIGNED: 7/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 15-1949
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart of Mary
24D. LOCATION (City, town, or county) (State): Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 13 1949
REGISTRAR'S SIGNATURE: Tomlinson for Williams, M.D.
25. FUNERAL DIRECTOR: Wm. S. Fiel Kowski
ADDRESS: 2007 Eastern Ave

VS 150

93D

G76249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

143 G76249

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sigfe Joseph

2. DATE OF DEATH July 11 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13 04

D. STREET ADDRESS (If rural, give location) 2928 Pankman Lane.

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH

9. AGE (In years last birthday) 66 If Under 1 Month: Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor

10B. KIND OF BUSINESS OR INDUSTRY B&O

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Joseph

14. MOTHER'S MAIDEN NAME Bentha Bunke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

DUE TO

(B) Hypertensive Cardiovascular disease — 10-15 Yrs

DUE TO Generalized arteriosclerosis

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Kaposi's hemorrhagic sarcoma — 2 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-11 *, 1949 to* 7-11 *, 1949, that I last saw the deceased alive on* 7-11 *, 1949, and that death occurred at* 4:20 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE Edith H. Schwenicke M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED July 11 '49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7-13-49

24C. NAME OF CEMETERY OR CREMATORY United Hebrew

24D. LOCATION (City, town, or county) Balto (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 13 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR Jack Lewis Inc. ADDRESS 2100 Eastern Ave

VS 150

53

G76250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G75250

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. MARY O. WICKER

2. DATE OF DEATH: 7-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: 10 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mt. Airy
D. STREET ADDRESS (If rural, give location): RFD # 3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
female	white	married	Jan. 19, 1877	72 71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Maryland	USA

13. FATHER'S NAME: William H. Dempsey

14. MOTHER'S MAIDEN NAME: Mary O. Gillis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		Union Memorial Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute coronary artery occlusion — INTERVAL BETWEEN ONSET AND DEATH: immediate

DUE TO

(B) arteriosclerotic heart disease — several years

DUE TO

(C) generalized arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 2, 1949, *to* July 12, 1949, *that I last saw the deceased alive on* July 12, 1949, *and that death occurred at* 7:55 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. A. Ranson M. D.	Union Memorial Hospital	7-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/15/49	PINE GROVE	Lonaconing Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 13 1949	Tuttington Williams, MD	L. M. Wentz & Son	Lonaconing Md

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

676251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No. 676251

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clarence Bing

2. DATE OF DEATH 7/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2514 Division St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hosp. D.O.A.
c. Length of stay in Baltimore 20yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 580 Oxford St 12-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Married	9/12/1903	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Night Cashier	Kelley Buick Co.	S.C.	U.S.A.

13. FATHER'S NAME Golden Bing

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	215-01-6905	Ozella Bing (W)	580 Oxford St

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive C.V. Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry? *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐ undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Kruger M.D.		7-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/13/49	Arbutus Mem'l. Pk,	Balto. County, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 13 1949	Huntington Williams, M.D.	Charles G. Cooper	512 Carrollton Av

VS 151

93D

G76252

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76252
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Sarah McCoy Ritchie

2. DATE OF DEATH: July 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1413 E Madison St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1413 E. Madison St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	C.	Married	Oct 8 1897	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore Md.	

13. FATHER'S NAME: Maud Roberts

14. MOTHER'S MAIDEN NAME: Jennie Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Robert McCoy ADDRESS: 1413 E Madison St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cancer of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension; renal insufficiency — 18 mo

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 19, 1947 *to* July 10, 1949 *that I last saw the deceased alive on* July 9, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert W. McDaniel M. D.	817 N. Caroline St	7-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 15/49	Mt. Calvary Cem.	Bal. County Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 13 1949	Huntington Williams, M.D.	Wm. Robt. C. Ellis & Daughs	1129 N. Caroline St. 48a

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 5423 Registered No. 075253

1. NAME OF DECEASED (Type or Print): Anna Taylor Smithers
2. DATE OF DEATH: 11 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 101 W. Monument St. 11-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Divorced	July 2. 1870	79				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	-	Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benj. Taylor	Annie Atkinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		none	Mr. F. Osborne Wilhelm	1203 Poplar Hill Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic Cardio-Vascular Disease with Cardiac Decompensation	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Fracture, Left Femur, healed	6 mos.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
Wm. H. Kammer, J. M.D.		12 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/13/49	Spring Hill Cem.	Easton, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 13 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS INC.	North & Pa. Balto. 17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

937

G7S254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77 Registered No. G7S254

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CALDWELL, ROBERT

2. DATE OF DEATH 7-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. HOSP.

C. Length of stay in Baltimore 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 22-01 1402 W Montgomery St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	C	W	5/12/1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEVEDORE
10B. KIND OF BUSINESS OR INDUSTRY Water Front
11. BIRTHPLACE (State or foreign country) Jamaica B-W-I.
12. CITIZEN OF WHAT COUNTRY? U-S-A
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Alberta Scott 1402 W Montgomery St ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic carcinoma DUE TO

(B) Carcinoma of prostate DUE TO

(C) Hypostatic pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cardiovascular and Renal

INTERVAL BETWEEN ONSET AND DEATH: Unknown

19A. DATE OF OPERATION June 29, 1949
19B. MAJOR FINDINGS OF OPERATION Carcinoma of Prostate
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 11 1949 8:50 a.m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11 July, 1949 to 11 July, 1949 that I last saw the deceased alive on 11 July, 1949, and that death occurred at 8:50 a.m., from the causes and on the date stated above.

23A. SIGNATURE J. W. Stone M. D.
23B. ADDRESS UNIV. HOSP
23C. DATE SIGNED 11 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/16/49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary St
24D. LOCATION (City, town, or county) (State) A. A. Co., Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 13 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS J. L. Brown & Son 1082 Montgomery St

VS 150

51B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75255 ~~4 Yrs~~ CERTIFICATE CORRECTED 7-13-49 G75255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ~~Herman~~ Harmon Blyther

2. DATE OF DEATH: July 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Osler Med.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY 6 05
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 124 N. Bond St

5. SEX: Male | 6. COLOR OR RACE: Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 1-27-1894 | 9. AGE (In years last birthday): 55 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): S. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Jack Blyther

14. MOTHER'S MAIDEN NAME: Dolly Charles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-07-9751

17. INFORMANT: Johns Hopkins Hosp. ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Incorrect age is especially important. Physician please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs

DUE TO

(B) Hypertensive Cardiovascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-10-, 1949 *to* 7-10-, 1949, *that I last saw the deceased alive on* 7-10-1949 *and that death occurred at* 4 a *m., from the causes and on the date stated above.*

23A. SIGNATURE: David Lukens M. D. | 23B. ADDRESS: Johns Hopkins Hosp. | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE: July 14-1949 | 24C. NAME OF CEMETERY OR CREMATORY: St. Phillips and Camden | 24D. LOCATION (City, town, or county) (State): SC

DATE RECEIVED BY LOCAL REGISTRAR: JUL 13 1949 | REGISTRAR'S SIGNATURE: Turlington Williams, M.D. | 25. FUNERAL DIRECTOR: Robert E. Williams | ADDRESS: 1515 McCulloh

937

G76256

BIRTH NO. G76256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 3698

1. NAME OF DECEASED (Type or Print): VICTORIA HAMPTON

2. DATE OF DEATH: 7-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1646 N. Gilmor St

c. Length of stay in Baltimore: 30 — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 1646 N. Gilmor St. 1-5-01

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 3, 1909
9. AGE (In years last birthday): 40
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Palmer Springs Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Moss

14. MOTHER'S MAIDEN NAME: Carolyn Evans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Elenora Butts ADDRESS: 1108 W. North Ave

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the cause of death clearly and legibly. Physician: please write correct age if especially important.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Two years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-7-, 1947 *to* 7-12-, 1949 *that I last saw the deceased alive on* 7-11-, 1949 *and that death occurred at* 4:35 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Frank A. Saunders M. D.

23B. ADDRESS: 1029 N. Stricker St.

23C. DATE SIGNED: 7-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 7/15/49

24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn

24D. LOCATION (City, town, or county) (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 13 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Geo. W. Kelson ADDRESS: 1303 Pennsylvania Ave

VS 150

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G76257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

41 Registered No. G76257

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Dorothy Loughran

2. DATE OF DEATH 7/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Agnes Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ellicott City
D. STREET ADDRESS (If rural, give location) Columbia Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	white	married	2/14/1901	48	5	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Mc Neil

14. MOTHER'S MAIDEN NAME Mary Hanson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Jerome A Loughran - Ellicott City

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Massive Hemorrhage tongue-Post	24 hours
	DUE TO Radium Therapy	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Squamous Cell Epithelioma Tongue	10 years
	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION 9-1-48 - 5-8-49

19B. MAJOR FINDINGS OF OPERATION Squamous Cell Epithelioma Tongue

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/11/49, 19__, *to* 7/12, 1949 *that I last saw the deceased alive on* 7/12/49, 19__, *and that death occurred at* 10:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE R. B. Meadden M. D.

23B. ADDRESS St Agnes Hospital

23C. DATE SIGNED 7/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7-15-49

24C. NAME OF CEMETERY OR CREMATORY New Cathedral

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 13 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR ADDRESS T. C. Higinbotham Ellicott City Md. 45B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

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G76258 BALTIMORE CITY HEALTH DEPARTMENT No. 1 G76258

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FREDERICK-DEITZEL

2. DATE OF DEATH July 12. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1149 W. Hamburg

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 74 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-0

D. STREET ADDRESS (If rural, give location) 1149 W. Hamburg St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed	Dec 26. 1874	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster

10B. KIND OF BUSINESS OR INDUSTRY self.

11. BIRTHPLACE (State or foreign country) Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frederick Deitzel

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO.

17. INFORMANT Samuel N. M. Deitzel ADDRESS 1149 W. Hamburg St.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 da

DUE TO

(B) Bronchopneumonia — 1 da

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/10 1949 *to* 7/12 1949 *that I last saw the deceased alive on* 7/12 1949 *and that death occurred at* 805 *a. m., from the causes and on the date stated above.*

23A. SIGNATURE Joseph L Lankford M. D. | 23B. ADDRESS 675 Washington Blvd | 23C. DATE SIGNED 7/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE July 15/49 | 24C. NAME OF CEMETERY OR CREMATORY Western | 24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 13 1949 | REGISTRAR'S SIGNATURE [illegible] | 25. FUNERAL DIRECTOR Mr. Wm. John H. Deitzel & Son ADDRESS 5311 Edmondson Ave.

94a

G76259 BALTIMORE CITY HEALTH DEPARTMENT G76259

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clay ROBERT C. BIGGS

2. DATE OF DEATH 7/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General
c. Length of stay in Baltimore 38 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 17-01
D. STREET ADDRESS (If rural, give location) 508 W. Franklin St

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH Aug 16 '88
9. AGE (In years last birthday) 60 (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William H. Biggs

14. MOTHER'S MAIDEN NAME Anna Belle Andrews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ?

17. INFORMANT Mr. Bruce Biggs ADDRESS Millersville, Md.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician, please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anterior Myocardial Infarction - 5 days

DUE TO

(B) Coronary sclerosis

DUE TO

(C) Purulent pericarditis
Hypertension, Diabetes mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/8 19 *to* 7/12, 1949 *that I last saw the deceased alive on* 7/12 1949 *and that death occurred at* 6:35 P.M., *from the cause and on the date stated above.*

23A. SIGNATURE Charles J. Blank M.D.
23B. ADDRESS Maryland General
23C. DATE SIGNED 7/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/15/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Pk. Cem.
24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 13 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR WM. J. TICKNER & SONS INC. ADDRESS North & Pa. Baltimore 17.

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61

G76260 CERTIFICATE CORRECTED 1-6-49 G76260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY LEO LEONARD

2. DATE OF DEATH JULY 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 6

D. STREET ADDRESS (If rural, give location) 1624 N. Bond Street - 13

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	married	May 12, 1881	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pipe-fitter	Union Worker	Maryland Balto -	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Patrick H. Leonard	Bridget A. Ganley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	217-07-1051	1624 N. Bond Street - 13 Mrs. Elizabeth Leonard

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiorespiratory failure

DUE TO

(B) pneumonectomy for

DUE TO

(C) carcinoma of lung

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 12, 1949	Mass in left lung	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 9, 1949 *to* July 13, 1949 *that I last saw the deceased alive on* July 13, 1949 *and that death occurred at* 4:20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. Andrew Allen, M.D.	St Joseph's Hospital	7-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/16/49	Baltimore Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 14 1949	[redacted] Baltimore, Md.	HENRY SANDER & SONS, INC. BALTIMORE - 13, MARYLAND

47D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every question must be answered. Physician: please write the cause of death clearly and legibly. Be especially important.

G76261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91 G76261 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EMMA MARGUERITE APPEL

2. DATE OF DEATH July 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1818 E. 30th. Street

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1818 E. 30th. Street 9-16

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH June 20, 1867

9. AGE (In years last birthday) 82 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John F. Blaich

14. MOTHER'S MAIDEN NAME Margaret Warner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. none

17. INFORMANT 1818 E. 30th. Street, 18 Mrs. Clarence P. Lowe

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Rectum and Thorax — INTERVAL BETWEEN ONSET AND DEATH: 14 year

DUE TO

(B) cardiac Ca of lungs. bronchi

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION Oct. 1947

19B. MAJOR FINDINGS OF OPERATION Carcinoma Rectum

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE Fla Stroms M.D. M. D.

23B. ADDRESS 2878 Harford Rd

23C. DATE SIGNED 7-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial

24B. DATE 7/15/49

24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE for Williams M.D.

25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC BALTIMORE - 13, MARYLAND

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EUGENE HENRY BOEHL

2. DATE OF DEATH July 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hosp

C. Length of stay in Baltimore — Yrs. Life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-17
D. STREET ADDRESS (If rural, give location) 1704 Homestead St.

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH April 4, 1928
9. AGE (In years last birthday) 21 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank teller
10B. KIND OF BUSINESS OR INDUSTRY Bank
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Boehl
14. MOTHER'S MAIDEN NAME Bertha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. 219-22-9526
17. INFORMANT Hospital Records ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and correct age is especially important.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculous meningitis
DUE TO
(B) Miliary Tuberculosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/8/49, 19__, *to* 7/12/49, 19__, *that I last saw the deceased alive on* 7/12/49, *and that death occurred at* 10:05 *m., from the causes and on the date stated above.*

23A. SIGNATURE Thaddeus Swinski M. D.
23B. ADDRESS St. Joseph's Hosp
23C. DATE SIGNED 7/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/16/49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 13 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.
BALTIMORE - 13, MARYLAND

13B

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Catherine V. Koerner

2. DATE OF DEATH 7/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1161 Cleveland St.

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-02
D. STREET ADDRESS (If rural, give location) 1161 Cleveland St

5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 8/15/1868
9. AGE (In years last birthday) 80 81
If under 1 year: Months / Days
If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work
10B. KIND OF BUSINESS OR INDUSTRY at Home

11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME John Neuberth

14. MOTHER'S MAIDEN NAME Annie Dumbeau

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT Mrs Charles F. Koerner ADDRESS 1161 Cleveland

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. Be especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Failure — Interval between onset and death: 1 da

DUE TO

(B) Generalized Arteriosclerosis — 5 yr

DUE TO

(C) Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/10, 1949 *to* 7-13, 1949 *that I last saw the deceased alive on* 7/13, 1949, *and that death occurred at* 1 p m., *from the causes and on the date stated above.*

23A. SIGNATURE Dwight Lowe Carter M. D.
23B. ADDRESS 679 Washington Blvd
23C. DATE SIGNED 7/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/16/49
24C. NAME OF CEMETERY OR CREMATORY New Cathedral
24D. LOCATION (City, town, or county) (State) 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR JUL 13 1949
REGISTRAR'S SIGNATURE Thomas Jon Williams, M.D.

25. FUNERAL DIRECTOR John J. Cowan & Son
ADDRESS 901 Hollins St.

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4/10

Registered No.

1. NAME OF DECEASED (Type or Print): Martha Louise Grubb

2. DATE OF DEATH: July 13 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4 Upland Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at Home

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. COUNTY Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4 Upland Road 27-14

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Nov 29 1850 | 9. AGE (In years last birthday): 98 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10B. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Zachary T. Grubb

14. MOTHER'S MAIDEN NAME: Emma J. Lyon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. No

17. INFORMANT: Dr. Wilson Grubb (nephew) | ADDRESS: Balto.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Valvular heart disease: mitral Insuffic. — 20 years.
DUE TO Rheumatic fever.
Acute pulmonary edema — 1 hour.
(B)
DUE TO
(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* , 1937, *to* July 13, 1949 *that I last saw the deceased alive on* June 27 1949, *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lewis P. Hawkins Jr. M.D. | 23B. ADDRESS: 1207 Eutaw Place | 23C. DATE SIGNED: 13 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: July 15 49 | 24C. NAME OF CEMETERY OR CREMATORY: Loudon Park | 24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUL 13 1949 | REGISTRAR'S SIGNATURE: Carrington Williams, M.D. | 25. FUNERAL DIRECTOR: Stewart & Morris | ADDRESS: Balto.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

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Registered No.

BIRTH NO. B.C. 49-14129

1. NAME OF DECEASED (Type or Print): Girl Krause

2. DATE OF DEATH: July 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore, Inc.

c. Length of stay in Baltimore (Yrs. Mos. Days): Born here

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 619 Dunbarton Ave. 9-01

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: July 10, 1949
9. AGE (In years last birthday) If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min. 20½ hrs

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Raymond L. Krause

14. MOTHER'S MAIDEN NAME: Lillian Fowler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Lillian Krause
ADDRESS: 619 Dunbarton Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not guess. Correct age is especially important. Physician: please write those words in the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage into falx cerebri

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1949 to July 11, 1949 that I last saw the deceased alive on July 11, 1949 and that death occurred at 9:10 a.m., from the causes and on the date stated above.

23A. SIGNATURE: Sidney Green M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 7/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: JOHNS HOPKINS MEDICAL SCHOOL JUL 13 1949
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JUL 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR:
ADDRESS:

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G76266 BALTIMORE CITY HEALTH DEPARTMENT 31 G76266

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Mary Helen Harris

2. DATE OF DEATH: July 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3504 W. Rogers Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 3 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3504 W. Rogers Ave. 27-19

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 9, 1876
9. AGE (In years last birthday): 73 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Butler, Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank Andrews
14. MOTHER'S MAIDEN NAME: Emmaline ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Helen Harris Michael ADDRESS: 3504 W. Rogers

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage
DUE TO
(B) Arterio Sclerosis
DUE TO
(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1949 *to* July 13, 1949 *that I last saw the deceased alive on* 7/13, 1949, *and that death occurred at* 11:30 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Lee J. Volanick M. D.
23B. ADDRESS: 1710 Liberty Hts
23C. DATE SIGNED: 7/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: July 13, 1949
24C. NAME OF CEMETERY OR CREMATORY: Stone Church Cemetery
24D. LOCATION (City, town, or county) (State): Wheeling, W. Va.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 11 1949
REGISTRAR'S SIGNATURE: Tuttington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. J. Tickner & Sons, ADDRESS: North & Pa. Balto

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Hospital Disposal
G76292

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76267

BIRTH NO. B.C. 49-12780

1. NAME OF DECEASED (Type or Print): Frances Goodman

2. DATE OF DEATH: JUL 4 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-2
D. STREET ADDRESS (If rural, give location): 1034 E. Monument St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored		6-28-49			14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank Goodman
14. MOTHER'S MAIDEN NAME: Betty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write clearly and legibly.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Dextrocardia ? congenital
DUE TO
(B) hemorrhage
DUE TO
(C) cardiac failure

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐:
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-4, 1949, *to* 7-4, 1949, *that I last saw the deceased alive on* 7-4, 1949, *and that death occurred at* 11:10 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 7/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Hosp Disposal
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JUL 14 1949
REGISTRAR'S SIGNATURE: [signature] for Williams, M.D.
25. FUNERAL DIRECTOR: ADDRESS

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76268 ✓ Registered No.

1. NAME OF DECEASED (Type or Print) Frederick J. Holste Sr. 2. DATE OF DEATH July 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp DOA.

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 8-6
D. STREET ADDRESS (If rural, give location) 1646 N. Washington St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	6/29/1900	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper
10B. KIND OF BUSINESS OR INDUSTRY American Oil Co
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Holste
14. MOTHER'S MAIDEN NAME Anna Weber
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
16. SOCIAL SECURITY NO.
17. INFORMANT Wilfred Holste ADDRESS 1542 Gilbert St.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Pulm. Edema — INTERVAL BETWEEN ONSET AND DEATH 2
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE William L. Helfrich M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED 7/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/16/49	Parkwood	Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 14 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1217 E. Fayette St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76269 — Registered No. ____

1. NAME OF DECEASED (Type or Print): Annie R Seymour

2. DATE OF DEATH: July 12 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 719 E Chase St

C. Length of stay in Baltimore: Yrs. ____ Mos. ____ Days ____

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 719 E Chase St 10-1

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow | 8. DATE OF BIRTH: Jan 19 1873 | 9. AGE (In years last birthday): 76 | If Under 1 Year: Months ____ Days ____ | If Under 24 Hours: Hours ____ Min. ____

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Talbott Co Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Seymour
14. MOTHER'S MAIDEN NAME: Annie Reed

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Robert F Seymour ADDRESS: Kendall Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congestive Heart Failure — 5 days
DUE TO
(B) Arteriosclerotic Heart Disease — 10 yrs
DUE TO
(C) General Debilitation — 2 yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 8, 1949, to July 12, 1949, *that I last saw the deceased alive on* July 11 1949, *and that death occurred at* 7 7 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert B. Tunney M. D. | 23B. ADDRESS: 920 N Paca St | 23C. DATE SIGNED: 7-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 7/15/49 | 24C. NAME OF CEMETERY OR CREMATORY: Spring Hill | 24D. LOCATION (City, town, or county) (State): Easton Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 14 1949 | REGISTRAR'S SIGNATURE: Huntington Williams M.D. | 25. FUNERAL DIRECTOR: Williams Co Inc | ADDRESS: 1219 N Paca St

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76270

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76270

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE A. ALBRECHT

2. DATE OF DEATH: 7/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-9
D. STREET ADDRESS (If rural, give location): 1213 Coldspring Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		2/22/71	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Iron worker	Steel Business	Germany	

13. FATHER'S NAME: George Andreas Albrecht

14. MOTHER'S MAIDEN NAME: Caroline Berish

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	212-18-2290	Mrs C C Grubbs	1230 E Cold Spring Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac decompensation
DUE TO
(B) Aortic Aneurysm
DUE TO
(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/8, 19 49 *to* 7/13, 19 49, *that I last saw the deceased alive on* 7/13, 19 49, *and that death occurred at* 5 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles J. Blasek M. D.	Maryland General	7/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/16/49	London Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 14 1949	Huntington Williams, M.D.	Wilhom Col Inc	1217 N Paul St

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Please write the correct age is especially important. Physician, please write the cause of death clearly and legibly.

VS 150

96

G76271 ✓ 198.1 G76271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print): Maybelle Placide McGarvey

2. DATE OF DEATH: July 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's

C. Length of stay in Baltimore: 55yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 613 E. Chase St. 10-1

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan. 25, 1894
9. AGE (In years last birthday): 55 (If Under 1 Year: Months: 5, Days: 19; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School teacher
10B. KIND OF BUSINESS OR INDUSTRY: Baltimore City
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John J. McGarvey
14. MOTHER'S MAIDEN NAME: Anna M. Ward

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS: St. Joseph Hospital 1400 N. Caroline

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Retroperitoneal sarcoma
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: July 11, 1949
19B. MAJOR FINDINGS OF OPERATION: Retroperitoneal sarcoma
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 3, 1949, *to* July 12, 1949, *that I last saw the deceased alive on* July 12, 1949, *and that death occurred at* 5:00a m., *from the causes and on the date stated above.*

23A. SIGNATURE: L. Joseph Krejci M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: July 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-15-49
24C. NAME OF CEMETERY OR CREMATORY: New Cayhedral Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elmer W. Conklin
ADDRESS: 924 E. Eager St.

VS 150

464

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76272

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Michael J. Lanasa

2. DATE OF DEATH: July 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1203 Valley St.,
c. Length of stay in Baltimore: 56 Yrs. 8 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, City 10-1
D. STREET ADDRESS (If rural, give location): 1203 Valley St.,

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	7 4 1883	56	0	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Book Keeper	Schley Bros.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Michael Lanasa

14. MOTHER'S MAIDEN NAME: Anna Gentile

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	215-05-1180	Mrs. Mary E. Lanasa	1203 Valley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) angina pectoris due to coronary artery disease — 2 1/2 yrs.

DUE TO

(C) hypertension — ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 1947, *to* July 12, 1949, *that I last saw the deceased alive on* July 12, 1949, *and that death occurred at* 9 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. Silverfel M. D.	718 E. Preston St	14 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7 16 49	Holy Cross	Pocomoke Binney

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 14 1949	Huntington Williams, M.D.	Elmer W. Conklin 924 E. Eager St Md.

VS 150

94a

G76273 29864

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76273

1. NAME OF DECEASED (Type or Print): Charles Jenkins

2. DATE OF DEATH: 7- 10- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 13 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 658 Dover ST. Z 30 22-2

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: ? ? ?
9. AGE (In years last birthday): 46 ? (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): S.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Steven Jenkins
14. MOTHER'S MAIDEN NAME: Rebecca Pace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records B.C.H.
ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular Accident
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

II
(C)
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6- 23- , 19 49 *to* 7- 10- , 19 49 *that I last saw the deceased alive on* 7- 10- , 19 49 *and that death occurred at* 11.55 m. *from the causes and on the date stated above.*

23A. SIGNATURE: J. S. Rogers M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 7-10-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 7-15-49.
24C. NAME OF CEMETERY OR CREMATORY: MT. AUBURN
24D. LOCATION (City, town, or county) (State): BALTIMORE MD

DATE RECEIVED BY LOCAL REGISTRAR: JUL 15 1949
REGISTRAR'S SIGNATURE: Funkington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. A. JACKSON
ADDRESS: 916 PENNA. AVE.

832

G76274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

G76274 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rev. Paul Pollard

2. DATE OF DEATH: 7-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 17. 14-3
D. STREET ADDRESS (If rural, give location): 2106 Druid Hill Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	Colored	married	6- 1875	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Minister	—	Richmond Va.	U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Martha Pollard ADDRESS: 2106 Druid Hill

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular
DUE TO Sclerosis

(B)
DUE TO

(C)

D
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-1-49, *to* 7-9-49, *that I last saw the deceased alive on* 7-9-49, *and that death occurred at* 1:40 m., *from the causes and on the date stated above.*

23A. SIGNATURE: T. E. Brady M. D. | 23B. ADDRESS: Provident Hospital | 23C. DATE SIGNED: 7-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-14-49	Mt. Calvary	A. A. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Howard A. Jackson ADDRESS: 916 Penna. Ave.

VS 150

93D

G76275 GM 129866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

D G76275 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Robert Truitt

2. DATE OF DEATH 7- 10- 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1317 Madison Ave. 11-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Negro	M	? ? ?	60 ?				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?

10B. KIND OF BUSINESS OR INDUSTRY ?

11. BIRTHPLACE (State or foreign country) ?

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Eastern Ave
Records Balto. City Hospitals 4940

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic HeartDisease with Failure.	
DUE TO	(B) Generalized Arteriosclerosis.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Gangrene of Extremities with Amputation 6-Weeks.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6- 27- 1949	Gangrene Of Left Foot On Arteriosclerotic Basis	YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6- 23- , 1949, *to* 7- 10- , 1949, *that I last saw the deceased alive on* 7- 10- , 1949, *and that death occurred at* 11.45 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
G. L. Organ M. D.	B. C. H. 4940 Eastern Ave.	7- 11- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7-15-49	MT. AUBURN	BALTIMORE 30.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 14 1949	Huntington Williams, M.D.	Wm. A. Jackson - 916 Penna. Ave

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

CERTIFICATE CORRECTED 7-18-49 ✓ X

G76276 — BALTIMORE CITY HEALTH DEPARTMENT — G76276

CERTIFICATE OF DEATH

443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frederick P. Miller

2. DATE OF DEATH: 7/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Catonsville
D. STREET ADDRESS (If rural, give location): 818 Frederick Ave.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 9/12/~~80~~ 80
9. AGE (In years last birthday): 68
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Electrician
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Augustus Miller
14. MOTHER'S MAIDEN NAME: Bertha Ryan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Mrs. Rose Miller ADDRESS: 818 Frederick Ave

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

16. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage, ot. — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(B) Hypertensive CVD. — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/9 1949 to 7/12 1949 that I last saw the deceased alive on 7/12 1949, and that death occurred at 2 P.M., from the causes and on the date stated above.

23A. SIGNATURE: Herbert D. Luckes M.D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 7/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-15-49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo. A. Farley ADDRESS: Baltimore Hoyt St

VS 150

937

G76277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76277

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Donald Suttner

2. DATE OF DEATH JUL 13 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE N.Y. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buffalo

D. STREET ADDRESS (If rural, give location) 320 Jewett St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	12-15-24	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		N.Y.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Fred J. Suttner	Madgaline Schaetzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia Hemothorax — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

(B) Anastamosis constriction of to

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/16/49; 7/7/49 7/12/49	Hemothorax	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-13 1949 *to* 7-13 1949 *that I last saw the deceased alive on* 7-13 1949 *and that death occurred at* 10:25 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Victor R. Nelson M. D.	JOHNS HOPKINS HOSPITAL	7/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/15/49	Mt Covelary	Buffalo N.Y.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 14 1949	Huntington Williams, M.D.	Charles P. Towell-24-37	2 Monument Ave

VS 150

157 F

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

G76278 — 130224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G76278

1. NAME OF DECEASED (Type or Print): Elmer Lanehardt

2. DATE OF DEATH: 7-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2434 Foster Avenue 1-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Wid.	Oct. 7. 1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Aircraft Mfg

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Lanehardt

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchiectesis — INTERVAL BETWEEN ONSET AND DEATH: 1 Yr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pulmonary Emphysema — 2 Yrs.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Acute Cor Pulmonale — 2 Weeks.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-11, 19 49, *to* 7-13, 19 49, *that I last saw the deceased alive on* 7-13, 19 49, *and that death occurred at* 7:50 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: H. L. Rogers, M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 7-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/16/49	Oak Lawn	Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Zeiler Inc. ADDRESS: 4035 S. Wolfe St.

VS 150

95 c

PLEASE WRITE PLAINLY, with UNFADING INK. Every question must be answered. Write the cause of death clearly and legibly. Physician's please write the exact age is especially important.

G76279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

541 / G76279

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Zachariah thomas

2. DATE OF DEATH 7/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

c. Length of stay in Baltimore UNKNOWN (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24
D. STREET ADDRESS (If rural, give location) 353 S. Bonsal St. 26-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Male	White	Married

8. DATE OF BIRTH April 19 1882
9. AGE (In years last birthday) 67
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer
10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN
11. BIRTHPLACE (State or foreign country) South Wales
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Thomas
14. MOTHER'S MAIDEN NAME Jemima Lewis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. ?
17. INFORMANT. Mrs. Zachariah Thomas ADDRESS SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured Ulcer, Posterior
DUE TO
(B) Wall of Duodenum
DUE TO
(C) Diffuse Peritonitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/10, 1949 *to* 7/13, 1949 *that I last saw the deceased alive on* 7/13, 1949 *and that death occurred at* 8:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE William B. Cooper M.D.
23B. ADDRESS 1213 Light St.
23C. DATE SIGNED 7/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/16/49
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn
24D. LOCATION (City, town, or county) (State) Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 14 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Lilly & Zeiler Inc.
ADDRESS 403 S Wolfe St.

VS 150

1178

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as to information should be carefully supplied. The cause of death clearly and correctly age is especially important. Physician: please write the cause

G76280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76280 Registered No.

BIRTH NO. B.C. #9.11791

1. NAME OF DECEASED (Type or Print) Howard Greenberg

2. DATE OF DEATH 7/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

C. Length of stay in Baltimore 4 weeks (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto City 27-16
D. STREET ADDRESS (If rural, give location) 3412 Royce Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	Under 1 Year: Months	Under 1 Year: Days	Under 24 Hours: Hours	Under 24 Hours: Min.
Male	White	Single	June 12-49		1	32		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Balto Md	

13. FATHER'S NAME Henry Greenberg

14. MOTHER'S MAIDEN NAME Blanche Greenberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Henry Greenberg	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure
DUE TO (Multiple rhabdomyomata of heart
(B) Congenital Neoplasm (Benign)
DUE TO probably cardiac
(C) in origin

(over)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-13 1949 *to* 7-14, 1949 *that I last saw the deceased alive on* 7-14, 1949, *and that death occurred at* 5 05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Judith B Landau M.D.	Sinai Hospital, Baltimore Md.	7-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
	7/14/49	Hebrew Rosedale	Phila Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 14 1949	Huntington Williams, M.D.	Jack Lewis Jr	57E 2100 Eutaw St

VS 155

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. If unknown or not applicable, so state. Do not use dashes or leave blanks. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76281 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G76281

BIRTH NO. Blankenship

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print): Nannie B. Blankenship

2. DATE OF DEATH: 7/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hospital
c. Length of stay in Baltimore: 11 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: ~~Baltimore~~
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md
D. STREET ADDRESS (If rural, give location): 804 W Baltimore St. 18-1

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 5/25/1884
9. AGE (In years last birthday): 65 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10B. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Campbell Co. Va
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: William P. Walker

14. MOTHER'S MAIDEN NAME: Nora Morris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Houston B. Blankenship ADDRESS 804 W Balto

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Failure + Shock
DUE TO
(B) Intestional obstruction
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [x] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 13 July, 1949, to 14 July, 1949, *that I last saw the deceased alive on* 14 July, 1949, *and that death occurred at* 1:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard D Hosser M. D.
23B. ADDRESS: Univ. Hosp
23C. DATE SIGNED: 14 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/16/49
24C. NAME OF CEMETERY OR CREMATORY: Spring Hill ~~Mt. Pleasant Farm~~
24D. LOCATION (City, town, or county) (State): Lynchburg, Virginia ~~Edmonds, Va~~

DATE RECEIVED BY LOCAL REGISTRAR: JUL 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Townsend Son ADDRESS: Hollins St. 1228

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G76282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76282

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution: Mrs. Prout Convelescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 Lyndhurst St (If rural give location) 16-E
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Caroline A. Ruschmeyer

3 (b) If veteran, name war ---
3 (c) Social Security Account No. -----

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Wm. Ruschmeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1870

8. AGE: Years 79 | Months ½ | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name George Gundlach
13. Birthplace Germany

MOTHER
14. Maiden Name Catherina
15. Birthplace Germany

16 (a) Informant L. Lester Pistel
(b) Address 834 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16, 1949 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Loyton Park Cemetery

18 (a) Funeral director Frederick J. Dobel
(b) Address 1200 N. Lombard St.

19 (a) JUL 14 1949 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1949, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1949 to July 13 1949 and that I last saw him alive on July 12 49

Immediate cause of death	Duration
Cerebral Hemorrhage	1½ hrs
Terminal	
Due to General Arteriosclerosis	✓
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: ✓
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature Helen L. Packard M. D.
Address 121 Dafflen Ave Date signed 7/13/49

83a

G76283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G76283

1. NAME OF DECEASED (Type or Print) Charles J. Gullivan

2. DATE OF DEATH July 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1000 Darley Ave.

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore G-8
D. STREET ADDRESS (If rural, give location) 1000 Darley Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Nov. 5, 1903	45	8 / 8	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician	George R. Morris	Baltimore	

13. FATHER'S NAME: John A. Gullivan

14. MOTHER'S MAIDEN NAME: Anna T. Lawless

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	213-14-4738		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 19 48/49 *to* 7/11, 1949, *that I last saw the deceased alive on* 3/25, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sol Smith, M. D.	1223 N Charles	7/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 15 1949	New Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 14 1949	Huntington Williams, M.D.	Frederick A. Cole	1200 W. Lombard St.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

136

G76284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76284

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Daniel Frederick DeBarge, Sr.

2. DATE OF DEATH July 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 509 W. 28th Street

c. Length of stay in Baltimore 30 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-7
D. STREET ADDRESS (If rural, give location) 509 W. 28th Street

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower

8. DATE OF BIRTH Sept. 28, 1887

9. AGE (In years last birthday) 61 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Cutter

10B. KIND OF BUSINESS OR INDUSTRY Building

11. BIRTHPLACE (State or foreign country) New York

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Joseph N. DeBarge

14. MOTHER'S MAIDEN NAME Sarah Medore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-01-1838

17. INFORMANT Robert E. DeBarge ADDRESS 1106 W. 40th Street

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Hypertensive CVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) sudden
(B) ?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-9 1949 *to* 7-12 1949, *that I last saw the deceased alive on* 7-12 1949 *and that death occurred at* 11:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Lawrence J. Shimanek M. D.

23B. ADDRESS 3711 Falls Rd

23C. DATE SIGNED 7-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 15, 1949

24C. NAME OF CEMETERY OR CREMATORY Chesterfield

24D. LOCATION (City, town, or county) (State) Centreville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR JUL 14 1949

REGISTRAR'S SIGNATURE Temperton Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Burgee Funeral Home 3631 Falls Road

VS 150 LAWRENCE J. SHIMANEK, M.D.

93D

Please write plainly, with unfading ink. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G76285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G76285

1. NAME OF DECEASED (Type or Print) MRS. LUVINIA C. WISNER

2. DATE OF DEATH 13 JULY 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore UNKN. 40 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 13-6
D. STREET ADDRESS (If rural, give location) 3356 HICKORY AVE.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	W.	FEB 12, 1890	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HSEWIFE		VIRGINIA	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
CLINTON HAMMOND	IDA TEARLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	215-07-6658	SON, EARLE E. WISNER-SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CEREBRO-VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 5 1/2 WKS
DUE TO
(B) HYPERTENSIVE & ARTERIOSCLEROTIC VASCULAR DISEASE — YEARS.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
HYPERTENSIVE HEART DISEASE

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* June 4 1949 *to* July 13, 1949 *that I last saw the deceased alive on* July 13, 1949, *and that death occurred at* 9:55 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. F. Cottrell M. D.	Union Memorial Hospital	7/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 16-1949	Woodlawn	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 14 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as required by law. Physician: please write the cause of death clearly and legibly. Be especially careful that age is especially important. Physician: please write

G76286

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

41

Registered No. G76286

1. NAME OF DECEASED (Type or Print): Jacob Lewis

2. DATE OF DEATH: July 12, 1949

3. PLACE OF DEATH:
A. Baltimore City Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1705 N. Dallas St

C. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1705 N. Dallas St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Colored	Married	Feb. 9 1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Charlotte Co Va.	

13. FATHER'S NAME: Jacob Lewis Sr.

14. MOTHER'S MAIDEN NAME: Fannie Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Henrietta Lewis	1705 N. Dallas St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchio-Pneumonia
DUE TO
(B) Exposure + Colds
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 wks

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/1 1949 *to* 7/12 1949, *that I last saw the deceased alive on* 7-12 1949 *and that death occurred at* 3:20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Jas. R. Blake M. D.

23B. ADDRESS: 1103 N. Caroline

23C. DATE SIGNED: 7-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 16/49

24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem

24D. LOCATION (City, town, or county) (State): B. C. County Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 14 1949

REGISTRAR'S SIGNATURE: Baltimore, Md

25. FUNERAL DIRECTOR: Mr Robt J. Ellis & Daughter

ADDRESS: 1129 N. Carlin St 107

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Prepare in duplicate. Use typewriter if possible. Fill in all items completely and correctly. Write the cause of death clearly and legibly. Physician's signature is especially important. Please write the correct age in years, months, days, hours, or minutes.

G76287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4700 G76287

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John W. Kelly

2. DATE OF DEATH July 12 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1738 Ashland Ave.

c. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-4
D. STREET ADDRESS (If rural, give location) 1738 Ashland Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Married	June 7 1886	63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Night Watchman	Hoffberger Dec Co	Farmer Fork Va.	

13. FATHER'S NAME Charles Kelly

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	212-09-7[illegible]	Mrs. Emma Kelly	1738 Ashland Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arterio-sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 5/6 1949 to 7-12 1949 that I last saw the deceased alive on 7/12 1949 and that death occurred at 7 30 p m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	RAYMER BROWNE, M.D. 1520 EAST MADISON ST. BALTIMORE 5, MD.	7-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. [illegible] (City or County) (State)
Burial	July 16 1949	Mt. Calvary Cem	A.A. County Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 14 1949	Huntington Williams, MD	Wm. H. H. Elliott, Daughty	937 1129 N. Caroline St.

VS 150

Correct age is especially important. Physician please write the cause of death clearly and legibly.

G76288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. G76288

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ellwood Ernest Stewart

2. DATE OF DEATH July 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2321 Division St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN, (If outside corporate limits, write RURAL and give township) Baltimore 14-3
D. STREET ADDRESS (If rural, give location) 2321 Division St.

c. Length of stay in Baltimore Yrs. Life Mos. Days

5. SEX M.
6. COLOR OR RACE Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH June 3 1896
9. AGE (In years last birthday) 53 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Woodstock Howard County Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John H. Stewart
14. MOTHER'S MAIDEN NAME Mary A Stewart
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no
16. SOCIAL SECURITY NO.
17. INFORMANT Addie L Stewart ADDRESS 1019 Hedwig

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — 1 hr.
DUE TO
(B) Hypertension + Arteriosclerosis. — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 6-1- 1949 to 7-11 1949 *that I last saw the deceased alive on* 7-11 1949 *and that death occurred at* 10 30 A. m. *from the causes and on the date stated above.*

23A. SIGNATURE John G. Warren M. D.
23B. ADDRESS 22 E 4 Madison St
23C. DATE SIGNED 7-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 14 1949
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.
24D. LOCATION (City, town, or county) (State) B.C. County Md.
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR JUL 14 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mr. Otto G. Ellis & Son
1129 N. Caroline St 832

VS 150

Please write the cause of death clearly and legibly. Physician is especially important. Correct age is especially important.

Claude LANGSTON ✓ ✓ ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76289 ✓ Registered No. G76289

1. NAME OF DECEASED (Type or Print): Claude Langston — 2. DATE OF DEATH: 7/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 40 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township) 16-4
D. STREET ADDRESS (If rural, give location): 1813 Mosher Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Separated	11/6/1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Gardner		Sampson, NC.	

13. FATHER'S NAME: James Langston
14. MOTHER'S MAIDEN NAME: Martha Sneed

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Ollie Williams	1813 Moshes St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L. Royer M.D.		14 Jul 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/16/49	Mt Calvary	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 14 1949	Huntington Williams, MD	A. Halsted	918 Druid Hill Ave 930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. If unknown, write "unknown." If the cause of death is especially important, Physician please write the cause clearly and legibly.

G76290
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76290

1. NAME OF DECEASED (Type or Print): Peach, William J. Jr.

2. DATE OF DEATH: July 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: 24 — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Gwynn Oak
D. STREET ADDRESS (If rural, give location): 823 Liberty Rd. R.F.D. #7

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 15, 1889.
9. AGE (In years last birthday): 49
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant Owner
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William J. Peach.
14. MOTHER'S MAIDEN NAME: Margaret Doory

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service): None.
16. SOCIAL SECURITY NO.:
17. INFORMANT: R. Katherine Murphy ADDRESS: 823 Liberty Road.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrahosis of liver — INTERVAL BETWEEN ONSET AND DEATH: 1 Year
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 1949 to July 13, 1949 that I last saw the deceased alive on July 13, 1949, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Mary E. Mathews M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: July 13

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 16, 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: S. Howard Storey ADDRESS: 3207 W North Ave

VS 150

1240

Please write plainly with pen and ink. Be sure to state the cause of death clearly and correct age is especially important. Physician: please write the

G76291 — BALTIMORE CITY HEALTH DEPARTMENT — G76291

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Clarence I Drummond

2. DATE OF DEATH: July 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1713 Harlem Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1713 Harlem Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 1713 Harlem Ave
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md., 16-3
D. STREET ADDRESS (If rural, give location): 1713 Harlem Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	C	Single	June 10, 1900	49				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Grocer store owner.		Wattsville, Virginia	U. S. A.

13. FATHER'S NAME: Thomas Drummond

14. MOTHER'S MAIDEN NAME: Carolyn. ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Rev. S. R Drummond. ADDRESS: 1713 Harlem.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 4, 1949 *to* July 10, 1949, *that I last saw the deceased alive on* July 8, 1949, *and that death occurred at* 2:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bruce J. Benjamin M. D.	1834 Edmondson Ave.	July 10, 1949

24A. BURIAL, CREMATION OR REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/16/49	Mt. Zion Cem	Laurel Prince Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 14 1949	Huntington Williams, M.D.	Wm. Hatie R. Williams & Son	322

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76292

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 076292

1. NAME OF DECEASED (Type or Print): Hattie Snow

2. DATE OF DEATH: 13 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital (DOA)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Severna Park Md
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, (WIDOWED, DIVORCED) (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Sept 20, 1870	78 79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Germany	U. S. A.

13. FATHER'S NAME: — Leydecker

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Burkey — ADDRESS: 3210 E Biddle St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Wm. N. Kammer, Jr. M.D.	☑	14/4/7 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 15, 1949	Balto. Natl Cem.	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 14 1949

REGISTRAR'S SIGNATURE: Hunter Jon Williams, M.D.

25. FUNERAL DIRECTOR: John A. Moran — ADDRESS: 3000 E. Balto.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 183.5

BIRTH NO. G76293B

Registered No. G76293

1. NAME OF DECEASED (Type or Print) JULIUS MARTINKUS

N-803.0

2. DATE OF DEATH July 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 813 West Lombard Street

18-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	MARRIED	APRIL 10 1889	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chesapeake Paper Co
10b. KIND OF BUSINESS OR INDUSTRY Helper

11. BIRTHPLACE (State or foreign country) LITHUANIA

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT LEONARD MARTINKUS ADDRESS 813 W LOMBARD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull & Intracranial Hemorrhage

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	street	In front of 700 W. Balto. St.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 9, 1949 Apprx. 2:45 A. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Struck back of head on sidewalk in fall during altercation

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry; *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐.*

23A. SIGNATURE Earl L Kruger M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 13 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/15/49	Holy Redeemer	Belair Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 14 1949	Huntington Williams, M.D.	Charles W Kaebenstein	708 McHenry St

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G76294

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Vol. 1 G76294 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN HEINECKE

2. DATE OF DEATH 7-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1029 W Barre St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 1029 N Barre St
B. COUNTY
C. CITY OR TOWN Balto Md (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 21-1

c. Length of stay in Baltimore 63 Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	WHITE	Divorced	SEPT. 15 1886	63	10	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		BALTIMORE MD	USA

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. None

17. INFORMANT Mr Brewbaker ADDRESS 1029 N Barre

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Chronic and acute alcoholism 6-12 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-9-49, 19__, *to* 7-12-49, 19__, *that I last saw the deceased alive on* 7-9-49, 19__, *and that death occurred at* 3:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	642 Woh. Blvd	7-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/14/49	Holy Redeemer	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 14 1949

REGISTRAR'S SIGNATURE [signature] Evelyn Williams, M.D.

25. FUNERAL DIRECTOR Charles W Tackenberg ADDRESS

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R. V. Range

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G76295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

G76295

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Roland Grayson

2. DATE OF DEATH: 7/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore (Rural - Brooklyn)
D. STREET ADDRESS (If rural, give location): 300 Bishop Ave.

5. SEX: M
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 46 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARM HAND
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: SAMUEL GRAYSON

14. MOTHER'S MAIDEN NAME: ROSE BOWIE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): YES
(If yes, give war or dates of service): WW FIST

16. SOCIAL SECURITY NO.:

17. INFORMANT: EVA MOORE ADDRESS: 1555 LISLIE ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral Hemorrhage
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION, LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): none
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): none
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? none.

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23A. SIGNATURE: John R Hopkins M. D.
23B. ADDRESS:
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 7/15/49
24C. NAME OF CEMETERY OR CREMATORY: BALTO. NATIONAL
24D. LOCATION (City, town, or county) (State): BALTO Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: ROBERT E. JENNINGS ADDRESS: 2115 MADISON AVE

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83a

Please write the cause of death clearly and correct age is especially important. Physician:

G76296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76296

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Booth

2. DATE OF DEATH 7/13/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Agnes Hosp.

C. Length of stay in Baltimore 3 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5 26 10

D. STREET ADDRESS (If rural, give location) 612 N. Highland Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white		5/20/1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Waterman	Va.	

13. FATHER'S NAME Joseph Booth

14. MOTHER'S MAIDEN NAME Mary Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Lillian Ackiss	612 N. Highland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Bronchogenic

DUE TO Carcinoma

(B) Rt Base

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/12/49	Bronchogenic Carcinoma - Rt.	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/4 19 49 *to* 7/13 19 49 *that I last saw the deceased alive on* 7/13 19 49 *and that death occurred at* 3:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Saml Hyman Jr M. D.	St Agnes Hosp	7/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/16/49	Loudon Pk.	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 15 1949	Huntington Williams, MD	Philip Herwig Sons	2024 Orleans St

VS 150

47c

31

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G76297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76297

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thoma s F. Menzies

2. DATE OF DEATH: July 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 809 Winston Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 809 Winston Ave. 27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Ma le	White	Married	March 8, 1893	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur	Automobile	Baltimore, Md.	

13. FATHER'S NAME: Charles Menzies

14. MOTHER'S MAIDEN NAME: Christina Black

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Clarence F. Menzies, ADDRESS: 4020 Ridgecroft Road

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write the cause of death clearly and fully.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: one hour

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JULY 11, 1949, *to* JULY 12, 1949, *that I last saw the deceased alive on* JULY 11, 1949, *and that death occurred at* 12:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Crawford N. Kilpatrick, Jr., M. D.	6. E. Eager Street	July 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/15/49	Parkwood	Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 15 1949	Huntington Williams, M.D.	Willia m Cook, Inc.,	1217 St. Paul St.

VS 150

94a

G76298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51

G76298

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARION E. BLOMBERG

2. DATE OF DEATH: July 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 203 West 29th St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 203 West 29th St. 12-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Aug. 24, 1904	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Virginia	

13. FATHER'S NAME: Bernard S. Smith

14. MOTHER'S MAIDEN NAME: Margaret Gregory

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Carl A. Blomberg	203 West 29th St.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cancer of stomach & metastases

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10 June '49	Cancer of stomach & metastases.	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1949, *to* 14 July, 1949, *that I last saw the deceased alive on* 12 July, 1949, *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. E. Wiese M. D.	920 St. Paul St.	14 July '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/18/49	Moreland Park	Baltimore County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 15 1949	Huntington Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

46B

Write the cause of death clearly and legibly. Physician please write in ink. Correct age is especially important.

G76299

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

45

G76299
Registered No.

1. NAME OF DECEASED (Type or Print) Howard Owings

2. DATE OF DEATH 7-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
West Baltimore General Hos.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland COUNTY Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 714 N. Hilton Street
D. STREET ADDRESS (If rural, give location) X 16-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	2/24/1903	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cab driver	Diamond Cab Co	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Owings	Mary Roberts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
No	—	217-09-4066	Catherine E Owings 714 N. Hilton St

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the correct age if especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Rupture of aneurysm of
DUE TO
(C) Circle of Willis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7-14, 1949, *to* 7-14, 1949, *that I last saw the deceased alive on* 7-14, 1949, *and that death occurred at* 1045 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William H. Birdsong M.D.	W Balto	7-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/18/49	Mt. Olivet	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 15 1949	Huntington Williams, MD	Wm Cook Inc.	1217 St. Paul St.

VS 150

96

G76300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

760 5 G76300

Registered No.

BIRTH NO. B.C. 49-12280

1. NAME OF DECEASED (Type or Print): BRUCE WILLIAM LATTIK

2. DATE OF DEATH: JUNE 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSP
c. Length of stay in Baltimore: 5 DAYS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 301 EAST 29TH ST. 12-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	NEWBORN INFANT	JUNE 13, 1949	—		5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	BALTIMORE, MD.	U.S.A.

13. FATHER'S NAME: PAUL JOHN LATTIK

14. MOTHER'S MAIDEN NAME: ~~STELLA YEAGER~~ EUNICE COGGINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

(Physician: please write the cause of death clearly and correct age is especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MULTIPLE INTRACRANIAL PETECHIAL HEMORRHAGES
DUE TO
(B) PRECIPITOUS LABOR AND DELIVERY
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
ATHELECTASIS, LEFT LOWER LOBE

INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JULY 9, 1949, to JULY 13, 1949, *that I last saw the deceased alive on* JUNE 13, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert R. Milan M. D.	Union Memorial Hosp.	June 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Destroyed by Hospital	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 15 1949	Thurlington Williams, M.D.		

VS 150

160a

G76501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76501

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth Rosenblatt

2. DATE OF DEATH 7-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto Gen Hosp

C. Length of stay in Baltimore 59 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 15-03
D. STREET ADDRESS (If rural, give location) 1727 N. Smallwood St

5 SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
F	W	MARRIED		67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work		Russia	U.S.

13. FATHER'S NAME Moses

14. MOTHER'S MAIDEN NAME Yetta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mrs. Nathan Levin - 1803 N. Smallwood St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: about 1 1/2 weeks

DUE TO

(B) Arteriosclerotic Cardio-vascular Renal Disease — Unknown

DUE TO

(C) Diabetes Mellitus — Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY YES ☐ NO ☒

21A. ACCIDENT. SUICIDE. HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-6, 1949 *to* 7-13, 1949 *that I last saw the deceased alive on* 7-13, 1949, *and that death occurred at* 12 P m., *from the causes and on the date stated above.*

23A. SIGNATURE M.D.	23B. ADDRESS	23C. DATE SIGNED
Maurice D. Davis	West Balto Gen Hosp	7-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-15-49	Beth Isaac Adas Israel	Balto MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 15 1949	Huntington Williams, MD	Jack Lewis Inc - 2100 Eutaw Pl

VS 150

61

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G76302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G76302

1. NAME OF DECEASED (Type or Print) Rebecca FLAX

2. DATE OF DEATH July 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY of MARYLAND Hosp

C. Length of stay in Baltimore 55 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If Rural, give location) 4005 Fairmount Ave

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED.
8. DATE OF BIRTH
9. AGE (In years last birthday) 60 If Under 1 Year: Months / Days. If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Wife
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JACOB CHARLOW
14. MOTHER'S MAIDEN NAME MINNIE CAPLAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Harry Flax ADDRESS 4005 Fairmount

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) LEUKEMIA, MONOCYTIC
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypostatic PNEUMONIA.

INTERVAL BETWEEN ONSET AND DEATH: years.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* July 1, 1949, to July 14, 1949, *that I last saw the deceased alive on* July 13, 1949, *and that death occurred at* 3:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Mark E. Hall M. D.
23B. ADDRESS U of Md. Hosp.
23C. DATE SIGNED July 14 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/15/49
24C. NAME OF CEMETERY OR CREMATORY Beth Shalom
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 15 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Levin Inc
ADDRESS 2100 Eutaw Pl

VS 150

74a

Please write the cause of death clearly and fully. Physician: please write the cause of death clearly and fully. Physician: please write the cause of death clearly and fully. Physician:

G76303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76303

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs.Mary Pilachowski

2. DATE OF DEATH: July 14,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 707 S.Ann Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home

c. Length of stay in Baltimore: 55? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 31
D. STREET ADDRESS (If rural, give location): 707 South Ann Street

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Jan 7-1874
9. AGE (In years last birthday): 75
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): POland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob Drzymala

14. MOTHER'S MAIDEN NAME: Emelia Soltysiak

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs.Clara Wieciech
ADDRESS: 707 S.Ann Street

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO
(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Diabetes Mellitus — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/1, 1949 *to* 7/14, 1949 *that I last saw the deceased alive on* 7/14, 1949 *and that death occurred at* 2 25 *A.m., from the causes and on the date stated above.*

23A. SIGNATURE: Louis J. Krolla M.D.
23B. ADDRESS: 1801 Eutaw Pl.
23C. DATE SIGNED: 7/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 18-1949
24C. NAME OF CEMETERY OR CREMATORY: St.Stanislaus Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore City,Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR / ADDRESS: George A.Weber 705 South Ann Street

VS 150

61

G76304

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76304

Registered No.

1. NAME OF DECEASED (Type or Print): Emma B. Keene

2. DATE OF DEATH: 7/14/49 4:20 P.M.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5104 Beaufort Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 7-14
D. STREET ADDRESS (If rural, give location): 5104 Beaufort Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 7/4/1863
9. AGE (In years last birthday): 86
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John R. Bradshaw
14. MOTHER'S MAIDEN NAME: Rose E. Pearson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Rosalie Singer
ADDRESS: Beaufort Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteria - Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

DUE TO

(B) Acute Ulcerative Colitis — 1 year

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1945, *to* July 14, 1949, *that I last saw the deceased alive on* July 14, 1949, *and that death occurred at* 4:20 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Earl L. Chambers M. D.
23B. ADDRESS: 4108 Liberty Hts.
23C. DATE SIGNED: July-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 7/16/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Grove
24D. LOCATION (City, town, or county) (State): Golden Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc
ADDRESS: 1217 St. Paul St.

VS 150

937

G76305

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76305

1. NAME OF DECEASED (Type or Print): Anna Ramanauskas (Ramanauskas)

2. DATE OF DEATH: 7-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq. Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt. 25-05
D. STREET ADDRESS (If rural, give location): 4514 Curtis ave

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, (MARRIED) WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 12/13/1874
9. AGE (In years last birthday): 74
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: HW

11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME: Adomitis
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: George Ramanauskas ADDRESS: 4515 Curtis Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-11, 1949 *to* 7-12, 1949 *that I last saw the deceased alive on* 7-12, 1949, *and that death occurred at* 12 45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. J. Laham M. D.
23B. ADDRESS: Franklin Sq. Hospital
23C. DATE SIGNED: 7-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): July 16-1949
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross Cem.
24D. LOCATION (City, town, or county) (State): Anundel County Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph Kasmakas Inc ADDRESS: 602 Wash. Blvd

VS 150

937

Write the cause of death clearly and correct age is especially important. Physician: please write this

G76306 G76306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54-1

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE TALBERT RICE

2. DATE OF DEATH 7-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTO. GEN. HOSP

C. Length of stay in Baltimore — Yrs. LIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 20-05
D. STREET ADDRESS (If rural, give location) 529 S. SMALLWOOD ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	WIDOWED	3-1-1885	64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MACHINIST.	MISCELLANEOUS.	MARYLAND	

13. FATHER'S NAME WILLIAM RICE

14. MOTHER'S MAIDEN NAME — THOMPSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	—	

17. INFORMANT MRS ETHEL REED ADDRESS 529 S SMALLWOOD ST.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Perforated Ulcer	
	DUE TO (B) Uremia	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) Bleeding Peptic ulcer	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-11-49	Perforated gastric ulcer - Hemorrhagic peptic ulcer	YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-23, 1949, *to* 7-13, 1949 *that I last saw the deceased alive on* 7-13, 1949, *and that death occurred at* 8:35 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William W. Ridenour M.D.	W. B. G. H.	7-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7-16-49	LOUDON PARK	FREDERICK RD.

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE Thomas Williams, M.D.

25. FUNERAL DIRECTOR JOHN F. DENNY, INC. ADDRESS 715 LIGHT ST -30

JUL 15 1949

1170

G76307 Hooper G76307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lucy Jane Hooper

2. DATE OF DEATH: Julu 11-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 227 N. Dallas Court
c. Length of stay in Baltimore: 21 Days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 227 N. Dallas Court 6-05

5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widdow
8. DATE OF BIRTH: May-16-1870
9. AGE (In years last birthday): 70
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dosmestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Nottaway CO. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Camble Oliver
14. MOTHER'S MAIDEN NAME: Prudener Oliver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Janet T. Wilson ADDRESS: 227 N. Dallas Court

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician please write the exact age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Aortic + mitral insufficiency — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) Hypochromic anemia — ?
DUE TO
(C) Debility.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-26, 1949, *to* 7-14, 1949, *that I last saw the deceased alive on* July 13, 1949, *and that death occurred at* 9P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. C. Burrel M. D.
23B. ADDRESS: 1/1 Aisquith
23C. DATE SIGNED: 7/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 19. 1949
24C. NAME OF CEMETERY OR CREMATORY: Fairview Cem.
24D. LOCATION (City, town, or county) (State): Philadelphia Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1000 Brantly Ave.

VS 150

92B

G76308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. G76308 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Hermione Riches

2. DATE OF DEATH JUL 15 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore 0 Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Kent
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chestertown
D. STREET ADDRESS (If rural, give location) 532 High St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	3-7-01	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Oregon
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Oliver C. Riches
14. MOTHER'S MAIDEN NAME Edna Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pulmonary embolus	?
	DUE TO (B) Rheumatic heart disease c	10 yrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) mitral stenosis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-18-1949 *to* 7-15-1949, *that I last saw the deceased alive on* 7-15-1949, *and that death occurred at* 3:40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Ernest C. Brown Jr. M. D. | 23B. ADDRESS JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED 7/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24B. DATE 7/16/49 | 24C. NAME OF CEMETERY OR CREMATORY Chestertown | 24D. LOCATION (City, town, or county) (State) Chestertown, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 15 1949 | REGISTRAR'S SIGNATURE Chestertown, Md. | 25. FUNERAL DIRECTOR Wm Cook Inc. | ADDRESS 1217 St Paul St.

VS 150

92B

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G76309 — 776 ✓ — G76309

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): BABY GIRL STRICKLAND

2. DATE OF DEATH: 7-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2907 Hillen Road 9-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	W	Single	7-15-49				7	15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Maryland	U.S.

13. FATHER'S NAME: Alfred Milton Strickland

14. MOTHER'S MAIDEN NAME: Audrey Elizabeth Poulman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO				

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

(B) Premature Separation Placenta

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 12 AM 7-15, 1949 *to* 8:35 AM 7-15, 1949, *that I last saw the deceased alive on* 8 AM 7-15-49 *and that death occurred at* 8:35 A m. *from the causes and on the date stated above.*

23A. SIGNATURE: Walter C. Fuller M. D. | 23B. ADDRESS: Maryland General Hosp | 23C. DATE SIGNED: 7/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Burial	7-15-49	Western Cemetary	

DATE RECEIVED BY LOCAL REGISTRAR: JUL 15 1949

REGISTRAR'S SIGNATURE: Carrington Williams, M.D.

25. FUNERAL DIRECTOR: Harry H Witzke — ADDRESS: 4101 Edmondson Ave

160c

JL. -122590 Infirmary

G76310

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76310

1. NAME OF DECEASED (Type or Print) John C . Yates

2. DATE OF DEATH 7- 14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore — Yrs. 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1608 W. Baltimore ST. (Infirmary)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	White	Div.	Jan. 16 1878	71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNKNOWN	—	MD.	USA

13. FATHER'S NAME: John Yates

14. MOTHER'S MAIDEN NAME: Lucy Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, unless unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	—	B.C.H. Records	4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Myocardial Infarction	
	DUE TO Arterioclerotic Heart Disease	
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8- 31- , 19 48 *to* 7- 14- , 19 49 *that I last saw the deceased alive on* 7- 14- 19 49 *and that death occurred at* 5.51 AM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. S. Ozeas M. D.	B.C.H. 4940 Eastern Ave.	7-14-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7/16/49	ST. ALOYSIUS	LEONARDTOWN MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 15 1949	Huntington for Williams, MD	P.B. ROBINSON	LEONARDTOWN MD

VS 150

937

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 853

G76311

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM AUSBY

N-503-V

2. DATE OF DEATH July 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 603 West Lee Street

22-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored		Oct 10 1896	52 53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): stevedore

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) N. C

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Ausby

14. MOTHER'S MAIDEN NAME Mary ~~Ausby~~ Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Hattie Ausby ADDRESS 603 W Lee St

MEDICAL CERTIFICATION

(Please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and legibly.)

18.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Fracture of Skull & Intracranial Hemorrhage	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) ship

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Cottman Co., Canton R.R., Pier 2 26/6

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 11, 1949 3.30p.m.

21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR? Fell down the hold of a ship

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Frank L Royer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED 14 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 17 49

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary

24D. LOCATION (City, town, or county) (State) A.A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 15 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Sarah L Brown Son

ADDRESS 108 W Montgomery

172

VS 151

CERTIFICATE CORRECTED 7-18-49

G76312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76512

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ~~Emma~~ ~~Fowler~~ Dulany-Fowler

2. DATE OF DEATH 7/14/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3293 Milford Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 15 Yrs. 11 Mos. 22 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE ~~Maryland~~ B. COUNTY ~~Balto. Co.~~ Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5506 Stoningtonave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	married	May 21-1903	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Md.	U.S.

13. FATHER'S NAME James Heath Dulany, Dec.

14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	Raymond [illegible] Fowler	5506 Stoningtonave. Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 2 yrs
DUE TO
(B) Secondary Anemia — over 6 months
DUE TO
(C) Malnutrition — 6 months

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-15, 1949 *to* 7-14, 1949, *that I last saw the deceased alive on* 7-14, 1949 *and that death occurred at* 12 m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Thos. H. Abbott M. D.	4509 Liberty Heights Ave.	7-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 17-1949	Bridge Cemetery	Westminster, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 15 1949	Huntington Williams, MD	J. Bankard & Son	Westminster, Md.

VS 150

50

Please write the cause of death clearly and legibly. Exact age is especially important. Physician:

G76313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76313

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles Louis Cunningham

2. DATE OF DEATH July 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1223 Hollins St.

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18
D. STREET ADDRESS (If rural, give location) 1223 Hollins St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Dec. 26, 1880	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cabinetmaker	Antiques	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles L. Cunningham	Sarah Scarf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	None	Mary Cunningham	1223 Hollins St.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure — Interval between onset and death: 48hr.

DUE TO

(B) Coronary Heart Disease — 3 yr.

DUE TO

(C) Arteriosclerosis — 10 yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 5, 1946, *to* July 14, 1949, *that I last saw the deceased alive on* July 13, 1949, *and that death occurred at* 10:55 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas. Martin, Jr. M. D.	1933 W. Baltimore St.	7/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 16, 1949	Loudon Park	Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 15 1949	Huntington Williams, M.D.	Geo. L. Schwab	2101 Frederick Rue.

VS 10 JUL 16 1949

94a

G76314 Hucksoll

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 1 3

G76314 Registered No.

1. BIRTH NO.

2. NAME OF DECEASED (Type or Print) August W. D. Hucksoll — 2. DATE OF DEATH July 15. 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2010 Ramsay St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2010 Ramsay St 20-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year, last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	Nov. 3. 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Woolen Mill	Baltimore Md	

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Hypertension Emphysia — 1 year 6 mos

DUE TO

(C) Arterial Sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/11 1949 to 7/15, 1949 that I last saw the deceased alive on 7/15, 1949 and that death occurred at 5A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas A Reahn M. D.	2145 W Baltimore St	7/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/18/49	Loraine Park	Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 16 1949	Wellington Williams, M.D.	Tillman Co Inc	1217 St Paul St

VS 150

43a

Cut age is especially important. Physician please write the exact number of years, months, days and hours.

G76315

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76315
Registered No.

1. NAME OF DECEASED (Type or Print) **William H.Deiches Jr.**

2. DATE OF DEATH **July 15th.1949.**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **Esplanade Aprt.**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore **Lifetime.** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.**
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **13-1** **Esplanade Apts.**

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	White	Single.	Jany.30th.1879.	70	5	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired,		Balto.md.	

13. FATHER'S NAME **William H.Deiches.**

14. MOTHER'S MAIDEN NAME **Jenny Hecht.**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs.S.Weiler.	6 Slade Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Myocarditis** — INTERVAL BETWEEN ONSET AND DEATH: **6 Mos**

DUE TO

(B) **Coronary Sclerosis** — **2 yrs**

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	The Esplanade	7/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 17th 1949.	Balto. Hebrew Cem.	Balto.Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 16 1949	Huntington Williams, M.D.	Paul Landsberg Inc	1902 Eutaw Pl.

VS 150

93E

G76316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 G76316 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MILTON L. HANLINE

2. DATE OF DEATH July 15/1949

3. PLACE OF DEATH: a. Baltimore City, Maryland Emersonian Apt

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Emersonian Apts.

c. Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE City
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 13-1
D. STREET ADDRESS (If rural, give location) Eutaw Place, at Hendelman

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	July 29/1881	67	11	16

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Traveling Salesman
11. BIRTHPLACE (State or foreign country) Charlottesville Va
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Mr. Hanline
14. MOTHER'S MAIDEN NAME Rosella Letlesman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs M. L. Hanline ADDRESS Emersonian Apts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Abdominal Carcinomatosis — Interval between onset and death: 2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Carcinoma of the Stomach — 2 yrs.

DUE TO (C) Hypertension Cardiovascular Disease — 3 yrs.

Coronary Artery Disease — 3 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION 0
19b. MAJOR FINDINGS OF OPERATION 0
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* July 8th 1949 *to* July 15th 1949 *that I last saw the deceased alive on* July 15th 1949 *and that death occurred at* 4:20 *m., from the causes and on the date stated above.*

23a. SIGNATURE F. Lowell Shrinkoff M. D.
23b. ADDRESS Emersonian Apts
23c. DATE SIGNED July 15th 1949

24a. BURIAL, CREMATION, REMOVAL (Specify) Rld
24b. DATE July 19/49
24c. NAME OF CEMETERY OR CREMATORY Bath Olney Fields Cemetery
24d. LOCATION (City, town, or county) (State) Brooklyn Md
25. FUNERAL DIRECTOR David Samuelson & Son
ADDRESS 1902 Eutaw Place.

DATE RECEIVED BY LOCAL REGISTRAR JUL 16 1949
REGISTRAR'S SIGNATURE Hunterton Williams, M.D.

VS 150

46C

G76317

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76317

Registered No.

1. NAME OF DECEASED (Type or Print): Louis G. Polley

2. DATE OF DEATH: 7-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 603 Dunbarton ave

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 603 Dunbarton Ave 9-01

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Nov. 19, 1880
9. AGE (In years last birthday): 68 69
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman
10B. KIND OF BUSINESS OR INDUSTRY: Crown Cork & Seal Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Richard G. Polley
14. MOTHER'S MAIDEN NAME: Sarah Randall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): /
16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Mary Bossar
ADDRESS: 603 Dunbarton Ave

MEDICAL CERTIFICATION

Complete the cause of death clearly and legibly. Physician: please write the exact age in especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Generalized arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 8, 1949, *to* July 13, 1949, *that I last saw the deceased alive on* July 13, 1949, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Frederick J. Vollmer M. D.
23B. ADDRESS: 6100 York Road - 12
23C. DATE SIGNED: July 14 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-18-49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 16 1949
REGISTRAR'S SIGNATURE: Hunting for Williams, M.D.
25. FUNERAL DIRECTOR: John A. Moran
ADDRESS: 3010 E. Balt. St.

VS 150

94a

G76318

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76318

Registered No.

1. NAME OF DECEASED (Type or Print) Gould - FRANK E

2. DATE OF DEATH 7/15/49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-07
D. STREET ADDRESS (If rural, give location) 2908 Arlington Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	White	married	Nov. 24-1873	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Canada

12. CITIZEN OF WHAT COUNTRY? /

13. FATHER'S NAME ?.

14. MOTHER'S MAIDEN NAME ?.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO. 219-05-6201

17. INFORMANT Mrs Irving Gould ADDRESS 2908 Arlington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia left lower lobe - post operative — DUE TO

(B) Arteriosclerotic Cardiovascular disease & senile decompensation — DUE TO

(C) Partial Intestinal obstruction secondary to carcinoma of left kidney & Retroperitoneal hematoma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 days.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION Multiple cysts Lt. kidney & partial intestinal obstruction

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 7/15, 1949 *that I last saw the deceased alive on* 7/15, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE J. F. Hawkins, Jr. M. D.

23b. ADDRESS Franklin Square Hosp.

23c. DATE SIGNED 7/15/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-18-49

24c. NAME OF CEMETERY OR CREMATORY Moreland Park

24d. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 18 1949

REGISTRAR'S SIGNATURE Hunter for Williams, M.D.

25. FUNERAL DIRECTOR Leonard J. Lucke ADDRESS 5305 Harford.

937

VS 150

G76319

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76319

1. NAME OF DECEASED (Type or Print) Thomas Newton Pierpont (Pierpoint)

2. DATE OF DEATH July 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2111 Mt. Holly St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2111 Mt. Holly St., 15-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	Aug. 3, 1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Paper Hanger

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles V. Pierpont

14. MOTHER'S MAIDEN NAME Mary Jane Robier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Lawrence W. Hepburn ADDRESS 2111 Mt. Holly St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Low Blood Pressure Chronic — Interval between onset and death: 6 mo

DUE TO Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardiac Asthenia — 2 da

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 20, 1949, *to* July 15, 1949, *that I last saw the deceased alive on* July 15, 1949, *and that death occurred at* 4:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE E. Wortham M. D.

23B. ADDRESS 1202 St. Paul St.

23C. DATE SIGNED 7/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	7-18-1949	Loudon Park	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 19 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR G. Howard Strong ADDRESS 3207 W. NORTH AVE.

VS 150

737

G76320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76320

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Vernon Groves

2. DATE OF DEATH 7/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1610 E. 29th St.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1610 E. 29th St. 9-06

5. SEX M.

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED

8. DATE OF BIRTH 1/17/1899

9. AGE (In years last birthday) 50 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouse Foreman

10B. KIND OF BUSINESS OR INDUSTRY B&O R.R.

11. BIRTHPLACE (State or foreign country) MD

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William B. Groves

14. MOTHER'S MAIDEN NAME MARY C. BREEDEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Zelma L. Groves — ADDRESS 1610 E. 29th St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE John R Davis M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED 7/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7-18-1949

24C. NAME OF CEMETERY OR CREMATORY Loudon Park

24D. LOCATION (City, town, or county) Baltimore (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 16 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR J. Howard Young — ADDRESS 3207 W. North Ave.

94a

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Please write the cause of death clearly and legibly. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76321

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

145

G76321

Registered No.

1. NAME OF DECEASED (Type or Print) Mary Jane Brown

2. DATE OF DEATH 7-13-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1626 W. Saratoga St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1026 W. Saratoga St. 18 or

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	Col.	Widow	Oct. 1, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		West River Md	U.S.A.

13. FATHER'S NAME Lemiel Tasker

14. MOTHER'S MAIDEN NAME Rachel ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		NONE

17. INFORMANT Ruth Allen ADDRESS 1624 W. Saratoga St.

MEDICAL CERTIFICATION

Please write the cause of death clearly and correct age is especially important. Physicians:

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

DUE TO

(B) Malignant Hypertension — several years.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-1 , 19 49, to July 13 , 19 49 *that I last saw the deceased alive on* , 19 , *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	672 Edmondson Ave	7-15-49

24A. BURIAL, CREMATION OR REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	7-17-49	W. Auburn Cem	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 16 1949	Lenington Williams, M.D.	Mrs Katie R. Williams	822 N. Schroeder St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76322

Registered No. G76322

BIRTH NO. G76322

1. NAME OF DECEASED (Type or Print) Henry Spencer.

2. DATE OF DEATH July 13, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1576 W Fayette St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
a. COUNTY 1516 W. Fayette St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1516 W. Fayette St. 19-0 W

5. SEX male | 6. COLOR OR RACE C. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH 8-26-1911 | 9. AGE (In years last birthday) 38 | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer. | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) N.C. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Sandy Spencer.

14. MOTHER'S MAIDEN NAME Emily Johnson.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Nora Spencer. ADDRESS 1576 W. Fayette St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 11, 1949 *to* July 13, 1949, *that I last saw the deceased alive on* July 11 1949 *and that death occurred at* 12:03 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Milton Fisinger M.D. | 23B. ADDRESS 1429 W Fayette St | 23C. DATE SIGNED 7/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7-18-49 | 24C. NAME OF CEMETERY OR CREMATORY Mt Lion | 24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 16 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Mrs Katie R Williams Interstate | ADDRESS 2771 N

VS 150

94a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76323

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76323

Registered No.

1. NAME OF DECEASED (Type or Print) William Smith

2. DATE OF DEATH 7-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1015 N. Vincent St.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-07
D. STREET ADDRESS (If rural, give location) 1015 N. Vincent St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	M.	Jan. 2 1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Arthur Smith

14. MOTHER'S MAIDEN NAME Mary Jane ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO. (If yes, give war or dates of service)

17. INFORMANT Martha Smith ADDRESS 1015 N. Vincent St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the Stomach
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1948 *to* July 13, 1949, *that I last saw the deceased alive on* July 13, 1949, *and that death occurred at* 9:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE Gilbert L. Bonfiglio M.D.

23B. ADDRESS 722 N. Fulton Ave

23C. DATE SIGNED 7-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7-17-49

24C. NAME OF CEMETERY OR CREMATORY Laurel Cem.

24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 18 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Mrs. Victor R. Wilkins

ADDRESS 3121 Sheridan Ave

VS 150

46 B

G76324

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 G76324 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mabel E. Duncan

2. DATE OF DEATH: 7/16/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 2911 Echodale Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 15yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2911 Echodale Ave. 27-06

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 19, 1892
9. AGE (In years last birthday): 56 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Philadelphia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas R. Mervine
14. MOTHER'S MAIDEN NAME: Brace L. Goodwin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Walter M. Duncan — ADDRESS: 2911 Echodale Ave

MEDICAL CERTIFICATION

(Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.)

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO (B) Hypertensive Cardio-vascular disease

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Terminal coma

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 2, 1942, *to* July 16, 1949 *that I last saw the deceased alive on* July 14, 1949, *and that death occurred at* 10:45A m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. V. Hadsell, M. D.
23B. ADDRESS: 4706 Harford Road
23C. DATE SIGNED: July 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/20/49
24C. NAME OF CEMETERY OR CREMATORY: Arlington Cemt. Lansdowne Pa.
24D. LOCATION (City, town or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JUL 17 1949
REGISTRAR'S SIGNATURE: Warrington Williams, M.D.
25. FUNERAL DIRECTOR: William J. Tickner & Sons — ADDRESS: North & Pa. Aves

VS 150

937

G76825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

G76825 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lizzie Allen

2. DATE OF DEATH JUL 13 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1606 Barnes St 7-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	Colored	Married	5-28-00	49				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		N.C.	

13. FATHER'S NAME Cap Simmonds

14. MOTHER'S MAIDEN NAME Nellie Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write in ink. Correct age is especially important.

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) cerebral hemorrhage	
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) hypertensive cardiovascular	
	DUE TO	
	(C) disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-8- 49 *to* 7-13 49, *that I last saw the deceased alive on* 7-13 49, *and that death occurred at* 7 05 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dillerman D. Whitehill M. D.	JOHNS HOPKINS HOSPITAL	7-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 17-49	Mt Calvary Cem.	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 17 1949	Huntington Williams, M.D.	Elroy O. Wilson	1011 Beanty 93D Md

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76326 — Registered No. G76326

1. NAME OF DECEASED (Type or Print): John H. Schultze — 2. DATE OF DEATH: July 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: 1 Yrs. 72 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryalnd
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3115 Milford Ave. L8-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	-------	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist		Baltimore, Maryland	

13. FATHER'S NAME: John R. Schultze

14. MOTHER'S MAIDEN NAME: Rosalba Wimmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Agnes M. Schultze — ADDRESS: 3115 Milford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ / ASSISTANT MEDICAL EXAMINER ☒ / MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil L Regan M.D.		July 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/18/49	Lorraine	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 17 1949	Huntington Williams, M.D.	H. W. Meads and Son	505 N. Edwards St.

VS 191

94a

Please write the cause of death clearly and legibly. Correct age is especially important. Physician:

G76327 BALTIMORE CITY HEALTH DEPARTMENT G76327

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Elmer C. Nelson

2. DATE OF DEATH 15/4/49 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2755 Riggs Ave.
C. Length of stay in Baltimore LIFE 62- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2755 Riggs AVE 16-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	MARRIED	DEC. 19-1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN-RET METAL BUSINESS
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) BALTIMORE
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME CHRISTIAN H. NELSON
14. MOTHER'S MAIDEN NAME CHRISTINA R. REINHART
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT MRS. ELSIE NELSON ADDRESS 2755 Riggs AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE Wm. H. Karmun Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED 15 Jul 4 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 18-1949	New Cathedral Cem.	Baltimore-Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 17 1949
REGISTRAR Baltimore, Md.
25. FUNERAL DIRECTOR Geo. L. Berger Jr. ADDRESS 1512 Hollins St.

VS 1ST

94a

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G76328

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76328 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Dr. Max Alexander Novey

2. DATE OF DEATH July 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6210 Biltmore Avenue
C. Length of stay in Baltimore 30 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 6210 Biltmore Avenue

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Sept, 23, 1899
9. AGE (In years last birthday) 49 — If under 1 Year: Months 9, Days 23 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) New York City
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Abraham Novey
14. MOTHER'S MAIDEN NAME Betsy Oboler
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Myrtle Novey — ADDRESS 6210 Biltmore Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acted. H. D. & coronary — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs
DUE TO thrombosis.
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 29, 1948 *to* Jul. 16, 1949, *that I last saw the deceased alive on* 7/16, 1949, *and that death occurred at* 6, 45A m., *from the causes and on the date stated above.*

23A. SIGNATURE C. Edward Leach M. D.
23B. ADDRESS 14 E. Eager St.
23C. DATE SIGNED 7/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-18-49
24C. NAME OF CEMETERY OR CREMATORY Shaarei Zion Cem Co
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR JUL 17 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR S. Levinson & Bros
ADDRESS 1124-26 W North Avenue

VS 150

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G76329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76329

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rachel Melnikof 560.3

2. DATE OF DEATH July 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 200 Aisquith Street

c. Length of stay in Baltimore 44 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryalnd
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 200mAisquith Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Russia	USA

13. FATHER'S NAME Jessie Selenkow

14. MOTHER'S MAIDEN NAME Mandel London

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Rebekah Potter ADDRESS 3507 Ellamont Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis

DUE TO

(B) Ventral Hernia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 15, 1949 *to* July 16, 1949 *that I last saw the deceased alive on* July 16, 1949 *and that death occurred at* 8 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Kaderl	2306 Eutaw Pl Balto Md	7-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burail	7-17-49	Knesseth Israel	German Hill Road, Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 17 1949	Washington Williams, M.D.	S. Levinson & Bros. 1124 W North Ave.

93E

Please write the cause of death clearly and correct age is especially important. Physician: please write the

G76330 ✓ G76330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): BERTHA GLASER

2. DATE OF DEATH: 7-15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 4613 Park Heights

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt Sinai Home

c. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-0
D. STREET ADDRESS (If rural, give location) 1915 W North Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow		77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Aaron
14. MOTHER'S MAIDEN NAME: Bessie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Bessye Gusberg ADDRESS: 1915 W North

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO
(B) Cerebral thrombosis — 5 days
DUE TO
(C) Hypertrophic arthritis — 5 yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1 1949 *to* 7 15, 1949 *that I last saw the deceased alive on* 7/15, 1949 *and that death occurred at* 11:55 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Miller MD M. D.	2030 Wilkens ave	7/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-17-49	Hebrew Herring Run	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR	25. FUNERAL DIRECTOR	ADDRESS
JUL 17 1949	Washington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

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G 6331 ✓ G76331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 31

Registered No. July 16/49

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sheckna Lewis LEWIS

2. DATE OF DEATH ~~June 1866~~

3. PLACE OF DEATH: A. Baltimore City, Maryland 3801 Barrington Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 3801 Barrington Rd Baltimore B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 15-10

D. STREET ADDRESS (If rural, give location) 3801 Barrington Rd

c. Length of stay in Baltimore 59 yrs (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widowed	Jan 10-1866	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant	Shoe business	Poland	american

13. FATHER'S NAME Hymen Lewis

14. MOTHER'S MAIDEN NAME Serrah Klein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Mrs Pauline Diener	3800 Barrington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage & Paralysis — INTERVAL BETWEEN ONSET AND DEATH about 6 weeks

DUE TO

(B) Advanced Arteriosclerosis — ?

DUE TO

(C) Hypertension — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 13 *, 1949, to* July 16 *, 1949, that I last saw the deceased alive on* July 13 *, 1949, and that death occurred at* 3:10 *a. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter L. Dunbar M. D.	2220 Harrison Blvd.	July 16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-17-49	Ahi Chaim	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 17 1949	Registrar for Baltimore, Md	Jack Lewis Inc	2100 Eutaw Pl

VS 150

830

G76332

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1544 G76332

Registered No.

1. NAME OF DECEASED (Type or Print): Kay Susen Foley

2. DATE OF DEATH: JUL 16 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 0 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Ohio
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Swanton
D. STREET ADDRESS (If rural, give location): 302 Lincoln Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White		7-23-45	3 4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Ohio, Toledo	

13. FATHER'S NAME: William C. Foley

14. MOTHER'S MAIDEN NAME: Vera Vaughan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure

DUE TO

(B) Cerebral anoxia

DUE TO

(C) Congenital Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 14, 1949	Congenital Heart Disease	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-5 1949 *to* 7-16, 1949, *that I last saw the deceased alive on* 7-16, 1949, *and that death occurred at* 10:30 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard L. Kuffler, Jr. M.D.	JOHNS HOPKINS HOSPITAL	July 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	7/20/49	Swanton Cemetery	Swanton Ohio

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 19 1949	Washington Williams, M.D.	Charles P. Towell & Son	427 Edmondson Ave

157E

Effect age is especially important. Physicians: please write plainly. Use the cause of death clearly and legibly.

G76333 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76333 Registered No. 36252

1. NAME OF DECEASED (Type or Print) FRANK Simmons

2. DATE OF DEATH July 17, 1949 ~~Dec. 27, 1894~~

3. PLACE OF DEATH:
A. Baltimore City, Maryland Yes

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.

c. Length of stay in Baltimore 5 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE W. Va.
B. COUNTY 1
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hendricks
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Dec 27, 1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith helper

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Navio. I Simmons

14. MOTHER'S MAIDEN NAME Hanna Barkley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ant. Coronary Occlusion

DUE TO with myocardial infarct

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE J. Fleet M. D.

23B. ADDRESS So. Balto Gen'l Hosp

23C. DATE SIGNED 7-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal

24B. DATE 7/18/49

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State) Parsons W. Va.

DATE RECEIVED BY LOCAL REGISTRAR JUL 17 1949

REGISTRAR'S SIGNATURE Washington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Clarence F. Hoffmann 1639 Broadway.

VS 150

94a

G76334 BALTIMORE CITY HEALTH DEPARTMENT G76334

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Henry J. Benner — 2. DATE OF DEATH: July 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Ward 6 — B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 46 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md — B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-1 — D. STREET ADDRESS (If rural, give location): 1117 E. Decker St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	6-14-02	47				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sewer	Box Factory	Md.	

13. FATHER'S NAME: George Benner — 14. MOTHER'S MAIDEN NAME: Lydia Greenwich

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ~~Hyper~~ Cardiac failure
DUE TO
ANTECEDENT CAUSES
(B) Hypertension
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-17-, 1949 *to* 7-15-, 1949 *that I last saw the deceased alive on* 7-15, 1949, *and that death occurred at* 3:30 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Phillips S. Bagley M. D. — 23B. ADDRESS: JOHNS HOPKINS HOSPITAL — 23C. DATE SIGNED: 7-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/19/49	Mt. Carmel	O'Donnell St.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 17 1949 — REGISTRAR'S SIGNATURE: Washington Williams, M.D. — 25. FUNERAL DIRECTOR — ADDRESS: Clarence F. Hoffmann 1639 Broadway.

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G76335 BALTIMORE CITY HEALTH DEPARTMENT G76335

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): George Oeh

2. DATE OF DEATH: 7/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 805 S. Bouldin St

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md

D. STREET ADDRESS (If rural, give location): 805 S. Bouldin St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single		67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic Retired		Germany	

13. FATHER'S NAME: George Oeh Sr.

14. MOTHER'S MAIDEN NAME: Maria Nuetzel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		Gertrude Oeh 805 S. Bouldin St.

MEDICAL CERTIFICATION

(Correct age is especially important. Physicians: please write the cause of death clearly and legibly.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
C. P. Falkenske M.D.		7/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/18/49	Trinity	O'Donnell St.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 17 1949	Huntington Williams, M.D.	Clarence F. Hoffmann	1639 Broadway.

94a

506610 ✓X 546 G76336

G76336

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Carol Ann Borchardt

2. DATE OF DEATH JUL 17 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Ill.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chicago
D. STREET ADDRESS (If rural, give location) 10220 S. Emerald, St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	S.	1-28-43	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Illinois	

13. FATHER'S NAME William Borchardt

14. MOTHER'S MAIDEN NAME Margaret Felkamp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Stenosis — 6 yrs

DUE TO

(B) Heart block + cardiac failure — 24 hrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-6- 1949 *to* 7-17- 1949 *that I last saw the deceased alive on* 7-17- 1949 *and that death occurred at* 4:10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm H. Williams M. D.	JOHNS HOPKINS HOSPITAL	7/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/19/49	Chicago Ill.	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 17 [redacted]	Huntington Williams M.D.	Wm Cook Inc.	1217 St Paul St

VS 150

157E

G76337

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76337

Registered No.

570.5

1. NAME OF DECEASED (Type or Print) Saville Oliver SCOTT

2. DATE OF DEATH July 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U. S. Marine Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Churchton
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Married	unknown	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
oysterman	seafarer	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Scott	Laura ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	unk	unk	Records,	US Marine Hospital, Balto., Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebrovascular embolism	10 min.
	DUE TO (B) Hypertensive cardiovascular disease	unk
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Intestinal laparotomy, 7th post-op day,	1 wk

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Jul 9, 1949	Intestinal obstruction due to adhesions	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 8, 1949 19 , *to* July 16 , 1949, *that I last saw the deceased alive on* July 16 , 1949 , *and that death occurred at* 8:00 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	U. S. Marine Hospital	7/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/21/49	Grove Cemetery	Churchton, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 17 1949	[illegible] for Williams, M.D.	Brown & Hardesty	Glenville

VS 150

122B

G76338 BALTIMORE CITY HEALTH DEPARTMENT G76338

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) William H. DeLOACHE [redacted] 2. DATE OF DEATH 7/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) GREENWICK GARDEN APTS. GREENWICK & FREDERICK ROADS.
c. Length of stay in Baltimore ONE YEAR Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) GREENWICK & FREDERICK ROADS. 28-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	WHITE	MARRIED	APRIL 27,1901	48				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN
10B. KIND OF BUSINESS OR INDUSTRY SUNRAY SALES SERVICE WARREN, PA.
11. BIRTHPLACE (State or foreign country) ST. TALBOTTON, GEORGIA.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME WALTER ORLANDA DeLOACHE
14. MOTHER'S MAIDEN NAME MYRTLE STEVENSON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT MRS. ADDIE BURGERT DeLOACHE ADDRESS Greenwick Garden Apts Greenwick & Frederick Rds Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection-Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE John R. Davis, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED 7/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
REMOVAL	JULY 17,1949	TAMPA CEMETERY	TAMPA, FLORIDA.

DATE RECEIVED BY LOCAL REGISTRAR JUL 18 1949
REGISTRAR'S SIGNATURE Hattie Lee Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS WILLIAM J. TICKNER & SONS. NORTH & PA. AVES. BALTO. 17, MARYLAND

JUL 18 1949

94a

G76339

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76339

Registered No.

1. NAME OF DECEASED (Type or Print) Catherine V. Keefe

2. DATE OF DEATH 7/15/49 3 PM.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1211 N. Ellwood Ave

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Balto.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Md. 8 03
D. STREET ADDRESS (If rural, give location) 1211 N. Ellwood Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	White	Widowed	10/22/1871	77				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Talbot Co. Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Lynch	Margaret (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Elsie Alexander	1902 Ramsey St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion

DUE TO

(B) General arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
		WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4/4, 1949, to 7/15, 1949, *that I last saw the deceased alive on* 7/15, 1949, *and that death occurred at* 3 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Miller MD M. D.	2026 Wilkens ave	7/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/18/49	Western	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Twitty for Williams, MD	Wm Cook Inc.	1217 St. Paul st.

VS 150

94a

G76340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76340

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN FORMAN

2. DATE OF DEATH: July 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 445 E. 25th Street

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 445 E. 25th Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Jan 21, 1911	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mailer	Newspaper	Baltimore, Maryland	USA

13. FATHER'S NAME: Atwood Forman

14. MOTHER'S MAIDEN NAME: Susan (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W.W. No. 2	213-09-1961	Luretta M. Forman	445 E. 25th Street

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from; natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Carl L. Royer M.D.	CLR	7-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/19/49	W. S. National	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Huntington Williams, M.D.	Wm Cook Inc	1217 St. Paul St.

VS 151

94a

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G76341
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43

G76341
Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Mary Elizabeth Brooks

2. DATE OF DEATH: July 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1314 Dellwood Ave.

C. Length of stay in Baltimore: 62 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1314 Dellwood Ave 13-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	April 5, 1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	-	Laurel, Maryland	USA

13. FATHER'S NAME: Benjamin F. Arrington

14. MOTHER'S MAIDEN NAME: Louise E. Cornwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	--	Edward L. Brooks	1314 Dellwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Haemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

DUE TO

(B) Hypertensive C.V. Dis.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 8, 1949 *to* July 15, 1949, *that I last saw the deceased alive on* July 14, 1949, *and that death occurred at* 4.00 *m., from the cause and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward L. Horsey M. D.	4057 Falls Rd.	7/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 18, 1949	Lorraine Park Cemetery	Baltimore County, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Lurlington Williams, M.D.	Burgee Funeral Home	3631 Falls Road Balto.

VS 150

93D

G76342

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76342

1. NAME OF DECEASED (Type or Print) SARAH R. JAMES

2. DATE OF DEATH 7-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL

c. Length of stay in Baltimore 34 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 13 OF
D. STREET ADDRESS (If rural, give location) 35-35 CLIPPER Rd #1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	White	Widow	June 23-1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) VA.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Louis Davenport
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT MRS. OLIVE BAYNE ADDRESS 2045 DRUID PK DR.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) INTESTINAL OBSTRUCTION	2 WK
	DUE TO	
	(B) PERITONITIS	3 WK.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C) RUPTURE APPENDIX	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-24-49	RUPTURE APPENDIX & PERITONITIS	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-2, 19 49, *to* 7-15, 19 49 *that I last saw the deceased alive on* 7-15, 19 49, *and that death occurred at* 8:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. E. Martin M. D.	Maryland Gen. Hosp.	7-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 19-1949	Mount Carmel	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

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G76343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76343

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert Long Walker

2. DATE OF DEATH: July 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 5 Da (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Ohio
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Thompson~~ YOUNGSTOWN
D. STREET ADDRESS (If rural, give location): 422 Brayson Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		4-15-48	~~15 mos~~ 15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY?: —
13. FATHER'S NAME: Robert L. Walker
14. MOTHER'S MAIDEN NAME: ~~Marjorie Davis~~ MARGARET DAVIS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Congenital Heart Disease (Tetrology of Fallot)	15 mos.
	DUE TO (B)	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: 7/14/49
19B. MAJOR FINDINGS OF OPERATION: Tetrology of Fallot
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 13 *to* 9 *a.m.,* 1949 *to* July 17, 1949 *that I last saw the deceased alive on* July 17, 1949 *and that death occurred at* 9 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Clinton K. Nelson, M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 7/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 7/21/49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Poland, Ohio

DATE RECEIVED BY LOCAL REGISTRAR: JUL 18 1949
REGISTRAR'S SIGNATURE: Tuntington Williams, MD
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MD.

VS 150

157E

G76344

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76344 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES EDWARD MUNDROFF

2. DATE OF DEATH July 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 25 N. Linwood Avenue
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 25 N. Linwood Avenue 6-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Aug. 24, 1887	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	U.S.Govt.	Penna.	USA

13. FATHER'S NAME Franklin Mundroff

14. MOTHER'S MAIDEN NAME Mary Ann Walters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
yes	WW1	none

17. INFORMANT 25 N. Linwood Avenue -24
Mrs. Louise M. Mundroff

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma - stomach — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

(B) ? —

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) arteriosclerosis — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
about 1 yr. ago.	Ca - stomach	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/1, 1949, to 7/16, 1949, *that I last saw the deceased alive on* 7/14, 1949, *and that death occurred at* 2:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	M. D.	23B. ADDRESS	23C. DATE SIGNED
Louis F. Klemer		262 E. Monument St	7/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	7/19/49	Oaklawn Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS
HENRY SANDER & SONS, INC.
BALTIMORE - 13, MARYLAND

VS 150

46C

G76345 BALTIMORE CITY HEALTH DEPARTMENT G76345

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Taylor Hickey

2. DATE OF DEATH 7/17/49

3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2641 Harlem Ave.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-06 D. STREET ADDRESS (If rural, give location) 2641 Harlem Ave.

5. SEX F | 6. COLOR OR RACE W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Dec 10, 1866 | 9. AGE (In years last birthday) 82 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland, Ohio | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Robert Taylor

14. MOTHER'S MAIDEN NAME Ellen Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Elizabeth Hickey ADDRESS 2641 Harlem Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heart failure — INTERVAL BETWEEN ONSET AND DEATH 1 yr.

DUE TO

(B) Old age

DUE TO

(C) Arteriosclerosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 7/17, 1949 *that I last saw the deceased alive on* 7/16, 1949 *and that death occurred at* 4 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Maurice L Shub, M. D. | 23B. ADDRESS 1431A Reisterstown Rd | 23C. DATE SIGNED 7/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7/21/49 | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral | 24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR JUL 18 1949 | REGISTRAR'S SIGNATURE Twitty for Williams, MD | 25. FUNERAL DIRECTOR J. T. Stansbury | ADDRESS 2700 Edmondson Ave

VS 150

97

G76346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450-1 G76346 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret M. Carroll

2. DATE OF DEATH July 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ashburton House 3515 Hilton Road

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2904 Brighton Street 1607

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	May 29, 1868	81				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work

10B. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME ? Smith

14. MOTHER'S MAIDEN NAME Margaret Kunkel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO	NO	NO

17. INFORMANT Mrs. F. Forney ADDRESS 2904 Brighton St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Broncho. Pneumonia	3 days
ANTECEDENT CAUSES	DUE TO (B) Generalized Arteriosclerosis	about 2 yrs
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) Sclerosis of Endocardium + Obliterans of both Lower Extremities	about 6 mos.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(D) Gangrene of feet + Legs	about 6 mos.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 1948 *to* July 15, 1949 *that I last saw the deceased alive on* July 14, 1949 *and that death occurred at* 445 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Julius C. Bluck M. D.	5356 Reisterstown Rd	7/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/18/49	Woodlawn	Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 18 1949	Huntington Williams, M.D.	J.T. Stansbury 2700 Edmondson Ave.

VS 150

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G76347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45-0

Registered No. G76347

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Laura E.Taylor

2. DATE OF DEATH 7-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1502 E.Federal Street

c. Length of stay in Baltimore — Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY City
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1502 E.Federal Street 8-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	White	Widowed	9-4-1861	87	10	12	xxxx	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore,Md.	U.S.A.

13. FATHER'S NAME (~~Franklin Miles~~) John W.Miles

14. MOTHER'S MAIDEN NAME Grindel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
None		None	Mr.Charles E.Taylor	1502 E.Federal St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Arteriosclerosis

DUE TO

(C) Old Age

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
For Dr. J.R. Davis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	M. D. (SIGN OR ABST. MEDICAL EXAMINER)	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/16 *1949 to* 7/16 *, 1949, that I last saw the deceased alive on* 7/16 *, 1949 and that death occurred at* 8:16 a *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas L.Shub M. D.	1931 N.Monroe St.	7/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-19-49	Woodlawn Cemetery	Baltimore Co.Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Huntington Williams, M.D.	George J.Ruth,Inc.	1735 Harford Avenue

VS 150

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G76348

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76348 Registered No.

450.0

1. NAME OF DECEASED (Type or Print): MARY TILLIE — 2. DATE OF DEATH: 7/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1514 Division St Provident H

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Md — B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — D. STREET ADDRESS (If rural, give location): 700 W.Lafayette Av 14-02

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: 30yrs (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Married	3/12/1897	52	4	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Domestic	Norfolk, Va.	U.S.A.

13. FATHER'S NAME: Ollie Allen

14. MOTHER'S MAIDEN NAME: Jennie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	No	

17. INFORMANT — ADDRESS: Joseph Tillie Jr.617 Lafayette Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Arteriosclerosis: Renal, Cerebral, Sarcoma.

due to

(B) Cerebral Edema

due to

(C) Pulmonary Edema and Congestion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/14, 1949 *to* 7/15/49, 19__, *that I last saw the deceased alive on* 7/15/49, 19__, *and that death occurred at* 9:55A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Simon N. Carter, jr M. D.	1225 Penna. Av	7/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/20/49	Calvert Cemetery	Norfolk, Va.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 18 1949

REGISTRAR'S SIGNATURE: Thurlington Williams, MD

25. FUNERAL DIRECTOR — ADDRESS: Charles G.Cooper512 Carrollton Av.

VS 150

97

G76349

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76349

Registered No.

1. NAME OF DECEASED (Type or Print): Klein, Mr John Edward

2. DATE OF DEATH: July 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 7006. 40th St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for Incurables 7006. 40th St

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): formerly 3801 Mohawk Ave. 13-07

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 11-1862

9. AGE (In years last birthday): 86 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tobacco Business

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Klein

14. MOTHER'S MAIDEN NAME: Emma Martini

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Laura Fischer, R.N. ADDRESS: Home for Incurables

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 30 Minutes
DUE TO Arteriosclerosis (Generalized)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Sclerotic Heart Disease — 18 Months
DUE TO

(C) Rheumatoid Arthritis — 20 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/12, 1949 *to* July 17, 1949, *that I last saw the deceased alive* July 16, 1949, *and that death occurred at* 4:50 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: W Hampton Hesperger M. D.

23B. ADDRESS: 214 Medical Arts Building

23C. DATE SIGNED: 7/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 7/19/49

24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 18 1949

REGISTRAR'S SIGNATURE: Tuttington Williams M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

94a

G76350

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 1 G76350 Registered No.

1. NAME OF DECEASED (Type or Print) Decker, Henry M. — 2. DATE OF DEATH 7-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto. Gen Hosp.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2862 HARLEM AVE 16-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	NOV, 28, 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TICKET SELLER	WASHINGTON TERMINAL CO. WASH. D.C.	MARYLAND	

13. FATHER'S NAME: JAMES MILTON DECKER

14. MOTHER'S MAIDEN NAME: MARY IDA JONES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO.	709-09-0880	HENRY M. DECKER, JR.	4109 RIDGEWOOD AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebro-vascular hemorrhage	1 week
	DUE TO (B) Hypertensive Arteriosclerotic Cardio vascular renal disease	years
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) mitral insufficiency, aortic dilatation (marked); cardiac failure, old my. cardial infarction, pulmonary embolus	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. ~~MAJOR FINDINGS OF OPERATION~~	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7-11, 1949 *to* 7-16, 1949, *that I last saw the deceased alive on* 7-16, 1949, *and that death occurred at* 12:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marvin Od. Davis M. D.	West Balto Gen Hosp.	7-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	JULY 19, 1949	LOUDON PARK CEMETERY	FREDERICK AVE. BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Winston Williams, M.D.	WILLIAM J. TICKNER & SONS	NORTH & PA. AVES., BALTIMORE, 17, MD.

VS 150

131a

G76351

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76351

Registered No. White

1. NAME OF DECEASED (Type or Print): LULA GREEN

2. DATE OF DEATH: July 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1212 McCulloh Street

C. Length of stay in Baltimore: 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1212 McCulloh Street 11-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow	May 9, 1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Baltimore, Md.	U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No,		Mrs. Myrtle Wharton	1212 McCulloh St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cerebral Accident

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 9, 1948 *to* July 15, 1949, *that I last saw the deceased alive on* July 15, 1949 *and that death occurred at* 11:58 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Julius S. White M. D.	1832 Pennsylvania	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/18/1949	Arbutus Mem. Park	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Huntington Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave.

VS 150

832

G76352

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13 Registered No. Flatt G76352

1. NAME OF DECEASED (Type or Print): FANNIE E. WATSON

2. DATE OF DEATH: July 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1644 N. Gilmor Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1644 Gilmor Street 1501

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Oct. 19, 1887
9. AGE (In years last birthday): 61
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Chandler
14. MOTHER'S MAIDEN NAME: Mary Wise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mildred S. Fisher
ADDRESS: 644 N. Fulton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Interval between onset and death: 1 year?

DUE TO

(B) Hardening of the Arteries — 3 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 7, 1949 *to* July 15, 1949, *that I last saw the deceased alive on* July 15, 1949, *and that death occurred at* 7:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: William H. Watts, M. D.
23B. ADDRESS: 5104 Columbus Ave
23C. DATE SIGNED: 7/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/18/1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 150

47

CERTIFICATE CORRECTED 1-22-49 ✓

G76353

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76353

1. NAME OF DECEASED (Type or Print): Mary Elizabeth Flavin

2. DATE OF DEATH: July 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3306 Brighton St.

C. Length of stay in Baltimore: 39 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3306 Brighton St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Married	[illegible] 1893	56 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Woodbine, Md.	

13. FATHER'S NAME: Charles H. Buckingham

14. MOTHER'S MAIDEN NAME: Rosalbra McQuay

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		No	Mr. James M. Flavin	3306 Brighton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral Thrombosis — 5 days

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 10 1949 *to* July 16, 1949 *that I last saw the deceased alive on* July 15, 1949 *and that death occurred at* 7.25 AM *on the date and hour stated above.*

23A. SIGNATURE: Dr. R. Johnson M. D.
23B. ADDRESS: 4008 Edmondson Ave. 29
23C. DATE SIGNED: 7.16.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 19, 1949	Loudon Park Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Huntington Williams, M.D.	J. Miller Amoreau	510 Liberty Heights Ave.

VS 150

94a

G76354 129196

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76354

Registered No.

1. NAME OF DECEASED (Type or Print) Nathan Lewis

2. DATE OF DEATH July 15, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 45 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 513 N. Dallas St. 7-05

5. SEX M

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH March 2, 1885 (1845)

9. AGE (In years last birthday) 64 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Lewis

14. MOTHER'S MAIDEN NAME Nancy Jane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT B. C. H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF PANCREAS WITH LOCAL EXTENSION AND OBSTRUCTION OFCOMMON BILE DUCT.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-24-49, 19__, *to* July 15, 19 49 *that I last saw the deceased alive on* July 15 1949, *and that death occurred at* 12.05 AM *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.

23B. ADDRESS 4940 Eastern Ave.

23C. DATE SIGNED July 15 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried

24B. DATE July 18-49

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.

24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 18 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

FUNERAL DIRECTOR Elroy O. Wilson

ADDRESS 1005 Bentley ave

VS 150

469

Medical Examiners Case released to Hospital

G76355 — BALTIMORE CITY HEALTH DEPARTMENT — G76355

CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Lizzie Parker

2. DATE OF DEATH: July 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 12 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 8 N. Caroline St. J-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Single	1-6-98	51				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maid		Va.	

13. FATHER'S NAME: John Dickens

14. MOTHER'S MAIDEN NAME: Lou Fleetwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A), STATING THE UNDERLYING CAUSE LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
Carlyn Kyle M.D.
CHIEF MEDICAL EXAMINER

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Acute Cardiac Tamponade	15 min.
DUE TO (B)	Accidental perforation of right ventricle of heart.	15 min.
DUE TO (C)	Miliary Tuberculosis	Hrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Hospital	Johns Hopkins Hosp. Broadway & Monument St.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 15, 1949 4:15 P m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Diagnostic Procedure

22. *I hereby certify that I attended the deceased from* 7-11, 1949 *to* 7-15, 1949, *that I last saw the deceased alive on* 7-15, 1949, *and that death occurred at* 4:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Rubens M. D.	JOHNS HOPKINS HOSPITAL	7-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-20-49	Ft. Town Mem.	Frankford Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Huntington Williams, M.D.	Elwyn O. Wilson	1700 Brunt St.

VS 150

Certificate to be approved by Medical Examiner

760

G76356

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76356

Registered No.

1. NAME OF DECEASED (Type or Print): Irene Watkins

2. DATE OF DEATH: 7/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 581 Laurens St.

C. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 14 or
D. STREET ADDRESS (If rural, give location): 581 Laurens St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F.	C.	W	Sept ? 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Carl Carter
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wilhelmina Watkins ADDRESS: 581 Laurens St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

(B) Cardio Vascular Disease — 1 yr.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 2, 1949 *to* July 17, 1949 *that I last saw the deceased alive on* July 13, 1949, *and that death occurred at* 7:30 *A.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm Frey M. D.	1928 Penna Ave	7/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/19/49	Mt Auburn	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Huntington Williams, M.D.	Geo. B. Kelson	1139 Gardenen St

VS 150

61

G76357

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76357

Registered No.

1. NAME OF DECEASED (Type or Print) Mary L Jones

2. DATE OF DEATH 7/16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2439 Ethel

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md
D. STREET ADDRESS (If rural, give location) 2439 Ethel 13-03

5. SEX F

6. COLOR OR RACE C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W

8. DATE OF BIRTH 6/23/1864

9. AGE (In years last birthday) 85 | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ? Jones

14. MOTHER'S MAIDEN NAME Martha Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Herman L. Jones ADDRESS 1804 N. Carey St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Apoplexy

DUE TO Hemiplegia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/11, 19 49, *to* 7/16, 19 49, *that I last saw the deceased alive on* 7/15, 19 49, *and that death occurred at* 7:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Ben R Shelton M. D.

23B. ADDRESS 2139 Linden Ave

23C. DATE SIGNED 7/16-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/20/49

24C. NAME OF CEMETERY OR CREMATORY Mt Auburn

24D. LOCATION (City, town, or county) (State) Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 18 1949

REGISTRAR'S SIGNATURE Winston Tom Williams, M.D.

25. FUNERAL DIRECTOR Geo. B. Kelson

ADDRESS 1303 Eastern Ave

VS 150

8-3a

5-Transcripts

G76358

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76358

1. NAME OF DECEASED (Type or Print): Emma Esthella Smith

2. DATE OF DEATH: July 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3036 Edmondson Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland.
D. STREET ADDRESS (If rural, give location): 3036 Edmondson Avenue 16-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
F.	W.	Widowed	March 22, 1872	77	3	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home duties

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George W. Hill

14. MOTHER'S MAIDEN NAME: Jane Stephens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Ida G. Harvey - ADDRESS: 3036 Edmondson Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

DUE TO

(B) Squamous cell carcinoma of the uterus with generalized metastasis — 1947

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 19, 1947, *to* July 16, 1949 *that I last saw the deceased alive on* July 15, 1949, *and that death occurred at* 2 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis A. Kurz M. D.

23B. ADDRESS: 3030 Edmondson Avenue

23C. DATE SIGNED: July 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 19, 1949

24C. NAME OF CEMETERY OR CREMATORY: Laudon Park Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 18 1949

REGISTRAR'S SIGNATURE: Tuckerton Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Mamie C. Syfer- 1600 W. North Ave.

MS 150

48B

G76359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76359

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Momberger

2. DATE OF DEATH: 7/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 4-0X
D. STREET ADDRESS (If rural, give location): 639 W Fayette St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		1875	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	FIREMAN	WASH. D.C.	

13. FATHER'S NAME: — MOMBERGER

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Mr. ROBERT ALLMAN - 753 W. FAYETTE ST

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic C.V disease	
	DUE TO	
	(B)	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
C. L. Schleicher M.D.	☑	7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	July 18 '49	BALTO. NATIONAL	BALTO. MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JUL 18 1949	Twilington Williams, MD	Harry A Whyte - 410 EDMONDSON AVE

VS 151

937

BIRTH NO. G76360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

57 G76360 Registered No.

1. NAME OF DECEASED (Type or Print): PEARL ROBINSON

2. DATE OF DEATH: July 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 464 Manns Ct.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 464 Manns Court

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	April 10, 1898	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Rich Square, N.C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
David Bishop	Hannah Chaney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.			John T. Robinson	464 Manns Ct.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis
DUE TO
(B) Carcinoma of Pancreas
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Carcinoma of Pancreas	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 1949 *to* July 15, 1949, *that I last saw the deceased alive on* July 15, 1949, *and that death occurred at* 930A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr. I. B. Huggins / Dr. W. Moore M. D.	President Hospital	7/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/18/1949	Sandy Branch, N.C.	N. Carolina

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Washington Williams, M.D.	Holland Funeral Home	1031 Druid Hill Ave.

468

G76361

BIRTH NO. G76361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59.0 G76361

Registered No.

1. NAME OF DECEASED (Type or Print) W. Kennard Smith

2. DATE OF DEATH 12:55 A.M. 7-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto - Residence
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Doctors Hospital 2724 N. Charles St.

c. Length of stay in Baltimore 34 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 3026 Hudson St. (24) 1-0 1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	11-27-12	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman	Beth Steel	Galveston, Tex U.S.A.	America

13. FATHER'S NAME John W. Smith

14. MOTHER'S MAIDEN NAME Madeline Bouye

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	216-01-521	Mrs. M. Smith ADDRESS 3026 Hudson St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Cystic Lungs — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 7-16, 1949 *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 12:55 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis J. Elsas M. D.	2730 N Charles St	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-19-49	Holy Redeemer	Belair Rd - Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 18 1949	[illegible]	John J. Duda

114 E

BIRTH NO. G76362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76362

1. NAME OF DECEASED (Type or Print) Henrietta Jackson

2. DATE OF DEATH 7/15—45

3. PLACE OF DEATH:
A. Baltimore City, Maryland 551 S Paca

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 551 S. Paca st.

c. Length of stay in Baltimore 2 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 551 S. Paca B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto

D. STREET ADDRESS (If rural, give location) 551 S. Paca 22-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last Birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	W.		75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Rockyhock N.C.	USA

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Frank Pitt	551 S. Paca

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5/2 , 19 45 to 7/15 , 19 45 *that I last saw the deceased alive on* 7/14 , 19 45 *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Burt Letton M. D.	2133 W. North Ave	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 20, 1945	Greenfield	Hempstead N Y

DATE RECEIVED BY LOCAL REGISTRAR JUL 18 1945 — SIGNATURE OF LOCAL REGISTRAR

25. FUNERAL DIRECTOR — ADDRESS

Joseph A. Sivek 6614 Belair Rd

94a

VS 150

G76363 — E900.0 — G76363

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): AMELIA ANDRATHY N-994
2. DATE OF DEATH: July 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3414 Esther Place
C. Length of stay in Baltimore: 31 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3414 Esther Place 26-44

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Jan. 1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Hungary	U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Elmer L Andrathy	3414 Esther Pl

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 32 days.
DUE TO (B) Thrombosis Left leg. — 30 days.
DUE TO (C) Phlebitis Left leg. — 14 days
DUE TO Fall down Steps — June 17,

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
For Dr. C. J. Lubinski
Ralph Merrill M.D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, ~~SUICIDE~~, ~~HOMICIDE~~ (Specify): Accident — June 17 1949
21B. PLACE OF INJURY (e. g., in or about home, factory, street, office building, etc.): 3414 Esther Place
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3414 Esther Place - Balto Md 26/44
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): June 17 1949 6 P.m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Taking Trash can out + slipped on last steps - after rain + fell down steps.

22. I hereby certify that I attended the deceased from June 17, 1949, to July 15, 1949 that I last saw the deceased alive on July 14, 1949, and that death occurred at 5 50 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Melvin J Lamorshe M.D. | 23B. ADDRESS: 311 Eastern Ave | 23C. DATE SIGNED: July 16 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	July 19, 1949	Holy Redeemer	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John H. Moran | ADDRESS: 3000 E Balto St Balto 24 Md

186a

G76364

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1 74

G76364

Registered No.

1. NAME OF DECEASED (Type or Print): Alice S. Lacs

2. DATE OF DEATH: July 14-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2931 Edmondson Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 47 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1311 Glyndon Ave 21-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	W	married	Jan 1902	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor	Tailor	Baltimore	Yes

13. FATHER'S NAME: Gervase Stringer

14. MOTHER'S MAIDEN NAME: M. Brelat

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-01-4509

17. INFORMANT: William Lacs ADDRESS: 1311 Glyndon Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of uterus — INTERVAL BETWEEN ONSET AND DEATH: 10 months.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from April, 6, 1949 to July, 14, 1949 that I last saw the deceased alive on July, 14, 1949 and that death occurred at 6 P. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ed. Summerlin M. D.	Medical Arts Bldg.	6/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	July 17-49	Holy Redeemer	Belair Rd Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Washington Williams, M.D.	Joseph Kaminker Jr.	602 Wash.

VS 150

48B

G76365

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. G76365 Registered No. G76365

1. NAME OF DECEASED (Type or Print): SARAH NATKOWITZ
2. DATE OF DEATH: 7-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4652 Pimlico Road
c. Length of stay in Baltimore: 36 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-18
D. STREET ADDRESS (If rural, give location): 3611 Lucille Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH
9. AGE (In years last birthday) If under 1 year Months Days; If under 24 hours Hours Min.: 58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Israel
14. MOTHER'S MAIDEN NAME: Not Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Max Natkowitz ADDRESS: 3611 Lucille Ave

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Cardiac Failure
DUE TO
(B) Ch. Myocarditis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/27 1946 *to* 7/17, 1949 *that I last saw the deceased alive on* 7/17, 1949, *and that death occurred at* 5:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE: A. L. Hornstein M. D.
23B. ADDRESS: 204 E. Biddle St
23C. DATE SIGNED: 7/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-19-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

937

G76366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 97 6 G76366 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CARL D. CROWSON N 1853-1 | 2. DATE OF DEATH: July 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 3 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Texas
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lovelady
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	2-22-1915	34		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Merchant Marine	Lovelady, Texas	USA

13. FATHER'S NAME: Glover Crowson

14. MOTHER'S MAIDEN NAME: Kate Sparks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	456-24-8846	Glover Crowson	Lovelady, Texas

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bullet wound of Brain
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Hotel
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Room 301 Ritchie Hotel 506 E. Baltimore Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 14, 1949 ?P. m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earle M Bruyn M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): removal
24B. DATE: 7/18/49
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State): Crockett Texas

DATE RECEIVED BY LOCAL REGISTRAR: JUL 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Philip Herwig Sons ADDRESS 2029 Orleans St.

VS 151

164c

G76367

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153

Registered No. G76367

1. NAME OF DECEASED (Type or Print): Charles Henry Hilseberg, Sr.

2. DATE OF DEATH: July 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2046 E. Orleans St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
M.	W.	Married	Dec. 27, 1893	55				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Gas Co.	Baltimore	

13. FATHER'S NAME: Charles E Hilseberg

14. MOTHER'S MAIDEN NAME: Mary Laycock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		212-05-7005	Wm. Hilseberg.	2046 Orleans St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Ascending Colon

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) with Metastasis to the Liver

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Acute Pulmonary Embolism

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [x] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 29, 1949 *to* July 17, 1949 *that I last saw the deceased alive on* July 17, 1949 *and that death occurred at* 7:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. K. Kaan M. D.	1400 N. Caroline St.	July 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 20, 1949	Oak Lawn	Colgate?Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Ullrich Funeral Home ADDRESS: 2008 Orleans St.,

VS 150

46E

G76368

Dr. Calas
4 N. Fulton Ave.
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

177 G76368
Registered No.

1. NAME OF DECEASED (Type or Print): George Washington Hazell

2. DATE OF DEATH: July 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 529 East 21st Street

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 529 East 21st Street 9-28

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: July 4, 1880
9. AGE (In years last birthday): 69
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Levi Hazell
14. MOTHER'S MAIDEN NAME: Amelia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-09-3257
17. INFORMANT: Mrs. Ella Graham
ADDRESS: 529 E. 21st Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Prostate Gland — INTERVAL BETWEEN ONSET AND DEATH: 1 year.
DUE TO

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July 10, 1948, *to* July 17, 1949, *that I last saw the deceased alive on* July 15, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. Calas M. D.
23B. ADDRESS: 4 N Fulton
23C. DATE SIGNED: 7/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-19-49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 18 1949
REGISTRAR'S SIGNATURE: Tuntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Ruck
ADDRESS: 5305 Harford Road.

VS 150

51B

G76369

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76369

Registered No.

1. NAME OF DECEASED (Type or Print): Clara Sidor 401.1

2. DATE OF DEATH: 7-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq Hosp.

C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt. 24-02
D. STREET ADDRESS (If rural, give location): 636 E. Fort ave

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Feb 18, 1918
9. AGE (In years last birthday): 31 — If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: HW

11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Walter Sidor husband — ADDRESS: 636 E Fort Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Heart Disease — yrs.
DUE TO (mitral stenosis)

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-17, 1949, *to* 7-18, 1949, *that I last saw the deceased alive on* 7-18, 1949, *and that death occurred at* 750 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. J. Laham M. D.
23B. ADDRESS: Franklin Sq. Hosp.
23C. DATE SIGNED: 7-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-21-49
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill cemetery
24D. LOCATION (City, town, or county) (State): H. G. county Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles F. Dill
ADDRESS: 1501 E. Fort Ave

VS 150

58 B

G76370
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

17°

G76370
Registered No.

1. NAME OF DECEASED (Type or Print): NETTIE MARINE

2. DATE OF DEATH: July 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2928 Presstman St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2928 Presstman St. 12-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	March 6, 1893	56 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Baltimore, Md.	

13. FATHER'S NAME: Herman A. Tegler

14. MOTHER'S MAIDEN NAME: Nettie Carrill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		no

17. INFORMANT: Mrs. Ethel M. Ayres, daughter ADDRESS 704 Greenwood Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Carcinoma — 1 yr.

DUE TO

(C)

over

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 22 1949 *to* July 17, 1949 *that I last saw the deceased alive on* July 16, 1949 *and that death occurred at* 11: A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bryan F. Siegel M. D.	15 Greenwood Rd	July 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/19/49	Brookview Cem.	Brookview, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Evelyn Williams, MD	WM. J. TICKNER & SONS	Balto., Md.

VS 150

50

676371

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 676371

1. NAME OF DECEASED (Type or Print): MARY S. ROBINS

2. DATE OF DEATH: July 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3605 Hillsdale Rd. Anderson Nursing Home

c. Length of stay in Baltimore: 50 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2204 Roslyn Ave.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: July 14, 1871
9. AGE (In years last birthday): 78 yrs. (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ?
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William F. Speake
14. MOTHER'S MAIDEN NAME: Mary Radcliff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): none
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. John J. Ghingher ADDRESS: c/o National Central Bank, Balto. & Holiday Sts.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis — (Interval between onset and death): 2yrs

DUE TO

(B) Myocardial failure — (Interval between onset and death): 3days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-1- 1942 *to* 7-16- 1949, *that I last saw the deceased alive on* 7-16 1949, *and that death occurred at* 9P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Howard K. Warner M. D.
23B. ADDRESS: 2604 Garrison Blvd
23C. DATE SIGNED: 7-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/19/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

97

G76372

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

G76372

Registered No.

1. NAME OF DECEASED (Type or Print) John A. Cassell

2. DATE OF DEATH July 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2730 Harlem Ave.

c. Length of stay in Baltimore 38 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 2730 Harlem Ave. 16-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	2/3/1868	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Interior Decorator	Retired	Albany N. Y.	USA

13. FATHER'S NAME
Michael Sassell

14. MOTHER'S MAIDEN NAME
Mary Degnan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	NO	262.12.6280	Mary C. Cassell	2730 Harlem Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia. — 5 Days
DUE TO Cardio Vascular Renal Disease. — 5 Yrs.
Cerebral Hemorrhage — 5 weeks.

(B) CPC 2 Lungs — 2 Hrs.
DUE TO Cardiac Asthenia. — 4 Hrs.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 30, 1949, to July 16, 1949, *that I last saw the deceased alive on* July 16, 1949, *and that death occurred at* 10.30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	112 St Paul St	7/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	7/20/49	New Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Huntington Williams, M.D.	J.T. Stansbury	2700 Edmondson Ave.

VS 150

93D

BIRTH NO. G76373

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76373

1. NAME OF DECEASED (Type or Print) Willard Hendrickson

2. DATE OF DEATH July 13 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1948 N. Spring St. 9-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Single	9-4-31	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert Hendrickson	Edna Hickson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Transverse Myelitis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
(B) Tuberculous meningitis — 1 yr.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 1-5 1949 *to* 7-13 1949 *that I last saw the deceased alive on* 7-13 1949 *and that death occurred at* 9 55 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Rubens M. D.	JOHNS HOPKINS HOSPITAL	7-13-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 19, 1949	New Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 18 1949	Thurlington Williams, M.D.	Elroy O. Wilson	1000 Bramble

VS 150

14

G76374

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93

G76374
Registered No.

1. NAME OF DECEASED (Type or Print): Charlotte R. Bruder | Bruder

2. DATE OF DEATH: 18 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 78 Yrs. Mos. Dys.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2636 N. Charles St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	20 July 1871	77 8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Nurse	Nursing	Maryland	U.S.A.

13. FATHER'S NAME: William C. Schreyer (Deceased)

14. MOTHER'S MAIDEN NAME: Mary Gardner (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown	Unknown	Clara P. Schreyer	2636 N. Charles St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Severe anemia
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 14 July 1949, 19__, *to* 18 July, 1949 *that I last saw the deceased alive on* 18 July, 1949, *and that death occurred at* 1 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Howard Rasken M. D.	Mercy Hospital	18 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 21, 1949	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 19 1949	Huntington Williams, M.D.	William Cook, Inc.	1217 St. Paul St.

VS 150

73D

G76375

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76375

1. NAME OF DECEASED (Type or Print) Kyle H. Bowles

2. DATE OF DEATH 18 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Mercy Hospital (DOA)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 219 E. North Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	June 30, 1880	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Manager retired	A & P Stored	Altoona, Penna	

13. FATHER'S NAME: James Bowles

14. MOTHER'S MAIDEN NAME: Mary Elizabeth (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	216-09-6635	Mrs. Hope Bowles	219 E. North Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED 18/7/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 20, 1949	Moreland Memorial Park	Parkville Balto. Co. Md.

DATE RECEIVED BY LOCAL REG. JUL 20 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS: William Cook, Inc, 1217 St. Paul St.

VS 151

94a

G76376

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76376
Registered No.

1. NAME OF DECEASED (Type or Print) Thomas J. Sandy

2. DATE OF DEATH 7-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 603 Carswell St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	WHITE		11-15-1888	60	-	-	-	-

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Sandy
14. MOTHER'S MAIDEN NAME Maria Dunaway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Daughter-in-law ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASHD — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Pulmonary Tbc — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 7/13/49, 19__, to 7/17/49, 19__, *that I last saw the deceased alive on* 7/17, 1949, *and that death occurred at* 2:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Richard R. Beach, M. D.
23B. ADDRESS Union Memorial Hosp.
23C. DATE SIGNED 7/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal
24B. DATE 7/19/49
24C. NAME OF CEMETERY OR CREMATORY Farnham Church Cem.
24D. LOCATION (City, town, or county) Downings (State) Richmond Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR JUL 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR William Cook, Inc.
ADDRESS 1217 St. Paul St.

VS 150

13B

776377

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G776377

Registered No.

1. NAME OF DECEASED (Type or Print) SAMUEL SHAPIRO

2. DATE OF DEATH July 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1504 E. Baltimore Street
c. Length of stay in Baltimore 40 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1504 E Baltimore Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Russia	USA

13. FATHER'S NAME David Shapiro

14. MOTHER'S MAIDEN NAME Esther Yaffe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Sarah Shapiro	1504 E. Balto. Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchial Br. Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Carcinoma of Lung — ?
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 15 19 49 *to* July 18 19 49, *that I last saw the deceased alive on* July 18 19 49 *and that death occurred at* 12:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Shapiro M. D.	700 N. Gay St	7/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-19-49	Chr- Knesseth Israel	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 19 1949	Huntington Williams, M.D.	S. Levinson & Bros. 1124 N North Ave

VS 150

46F

76378

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 G76378

Registered No.

1. NAME OF DECEASED (Type or Print) Lovett, Barney

2. DATE OF DEATH 19 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 15-W
D. STREET ADDRESS (If rural, give location) 2302 OCALA AVENUE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Single	1880	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SALESMAN		PA.	USA.

13. FATHER'S NAME ZOVEL LOVETT

14. MOTHER'S MAIDEN NAME ESTHER ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		BENJAMIN GREBER	2302 OCALA AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of stomach + oesophagus

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
18 July 49	Large amount of sanguinolent fluid in abdomen	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-28, 1949 *to* 7-19, 1949, *that I last saw the deceased alive on* 7-19, 1949, *and that death occurred at* 1:15 AM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Eugene P. Lyons M. D.	Sinai Hospital	19 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7-19-49	SHAARE-ZION	BALTIMORE, MD.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 19 1949

REGISTRAR [redacted] Baltimore, Md.

25. FUNERAL DIRECTOR: S. LEVINSON & BROS. W. NORTH AVE. ADDRESS 1124

VS 150

46B

G76379

BIRTH NO. G76379

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): JULIUS BLANK

2. DATE OF DEATH: 7-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4613 Park Heights
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt Sinai Home
C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Penn
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Philadelphia
D. STREET ADDRESS (If rural, give location): 737 So 5th St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH
9. AGE (In years last birthday): 80 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Benjamin Berschler — ADDRESS: Phila. 730 Pine St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Edema DUE TO Cerebral Thrombosis & Coronary Arteriosclerosis & Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1948 to July 18, 1949 that I last saw the deceased alive on July 18, 1949 and that death occurred at 9P m., from the causes and on the date stated above.

23A. SIGNATURE: Dexter R. Kalman, M. D.
23B. ADDRESS: 3700 Park Heights Ave
23C. DATE SIGNED: July 19 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 7-19-49
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town or county) (State): Philadelphia Pa

DATE RECEIVED BY LOCAL REGISTRAR: JUL 19 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

838

G76380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17 Registered No. G76380

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EMMA-K-LURZ

2. DATE OF DEATH July 17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTO-MD

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3434 Cliftmont Ave

C. Length of stay in Baltimore Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 3434 CLIFTMONT AVE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 26-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	MARRIED	Sept 17-1897	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	—	Balto	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Valitine Schweiger	Elizabeth Dunnigan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mr George Lurz

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of left Breast - operated 7/x/35 — Treated by X Ray - Radium — last 4 years — (Kelly Hospital)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 3/1935	Carcinoma of left breast	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* July 1 1949 *to* July 17, 1949, *that I last saw the deceased alive on* July 17, 1949, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis F. Krumeich M. D.	722 No. Kenwood ave	July 18 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 21-49	Holy Redeemer	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 19 1949	Washington Williams, M	Joseph J Herr & Son	3001 Kentucky ave

VS 150

50

6381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76381

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN LeROY KEARNEY

2. DATE OF DEATH July 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3604 Clifton Ave.
C. Length of stay in Baltimore — Yrs. life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3604 Clifton Ave. 15-48

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Oct. 15, 1888
9. AGE (In years last birthday) 60 yrs. — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner
10B. KIND OF BUSINESS OR INDUSTRY Tile Contracting
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Wm. J. Kearney
14. MOTHER'S MAIDEN NAME Barbara Beck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Maud A. Kearney — ADDRESS 3604 Clifton Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — 1 da
DUE TO
(B) Coronary Disease — many
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ — NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/10 1949 *to* 7/18 1949, *that I last saw the deceased alive on* 7/18 1949, *and that death occurred at* 12 a m., *from the causes and on the date stated above.*

23A. SIGNATURE Lorenz G. Laubaith M. D.
23B. ADDRESS 679 Washington Blvd
23C. DATE SIGNED 7/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/21/49
24C. NAME OF CEMETERY OR CREMATORY Cathedral Cem.
24D. LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR WM. J. TICKNER & SONS — ADDRESS Balto., Md.

VS 150

94a

G76382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76382

BIRTH NO. 76382

1. NAME OF DECEASED (Type or Print) Edward M. McAllister

2. DATE OF DEATH July 17 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1440 E Fort Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Balto - Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - Md
D. STREET ADDRESS (If rural, give location) 1440 E. Fort Ave. 24-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	Single	Nov 25 1881	67	—	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairy Farm
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore - Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Nathaniel A. McAllister
14. MOTHER'S MAIDEN NAME Mary A. Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.
16. SOCIAL SECURITY NO.

17. INFORMANT Mrs J. L. McAllister ADDRESS 234 E Hamburg

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Mitral Regurgitation Hypertension Arterio Sclerosis — 14 yr. 14 yr

DUE TO

(C) Chronic Interstitial Nephritis — 14 yr

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 17 1949 *to* July 17 1949 *that I last saw the deceased alive on* July 16 1949 *and that death occurred at* 1.30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE L. F. A. Storms M. D.
23B. ADDRESS 2878 Harford Rd
23C. DATE SIGNED 7-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/19/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION (City, town, or county) (State) Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR JUL 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR J. Fabian Sons ADDRESS 13 E Lig[illegible]

VS 150

131a

G76383

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

17

G76383

Registered No.

1. NAME OF DECEASED (Type or Print): Frances M. Russell

2. DATE OF DEATH: July 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5346 Maple Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. COUNTY Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5346 Maple Ave. 27-17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	M.	Nov. 22 1902	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home.	Baltimore Md.	U.S.A.

13. FATHER'S NAME: Frank Haller

14. MOTHER'S MAIDEN NAME: Mae V. West.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Breast — INTERVAL BETWEEN ONSET AND DEATH: about 18 mos.

DUE TO with Metastases To Brain

(B) — INTERVAL: about 6 mos.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* February 1949 *to* July 17, 1949 *that I last saw the deceased alive on* July 16, 1949, *and that death occurred at* 2:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Julius C. Bleich M. D.	5356 Reisterstown Rd	7/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 20/49	Woodlawn	Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 19 1949	Huntington Williams, M.D.	Loring Byers	5005 Park Heights Ave

VS 150

50

G76384

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76384

1. NAME OF DECEASED (Type or Print): ANNIE LAURIE WOODWARD

2. DATE OF DEATH: July 17 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4338 N Charles St

c. Length of stay in Baltimore: 50 Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4338 N Charles St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Feb 6 1891	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Montgomery Ala

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: George Laurie

14. MOTHER'S MAIDEN NAME: Margaret Born

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Stanley Woodward — ADDRESS: 4338 N Charles

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency + Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension + Arteriosclerosis — 4 years

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan ____, 1945, to July 17, 1949 that I last saw the deceased alive on July 17, 1949, and that death occurred at 8 A. m., from the causes and on the date stated above.

23A. SIGNATURE: Francis W. Gluck M. D.

23B. ADDRESS: 3406 St Paul St

23C. DATE SIGNED: 7/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 19/49

24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge

24D. LOCATION (City, town, or county) (State): Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 1 9 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Henry Jenkins & Sons — ADDRESS: 4905 York Rd

94a

VS 150

G76385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76385

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MR. VERNON M. EBERT

2. DATE OF DEATH JULY 18-1949

3. PLACE OF DEATH
A. Baltimore City, Maryland 617 N. MONTFORD AVE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 617 N. MONTFORD
C. Length of stay in Baltimore LIFETIME 32 Yrs. 11 Mos. - Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTO. CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 617 N. MONTFORD AVE 7-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	D	AUGUST 24-1916	32	—	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto-Body Fender-Painter
10B. KIND OF BUSINESS OR INDUSTRY Paint.
11. BIRTHPLACE (State or foreign country) BALTIMORE, Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MR. JOHN EBERT
14. MOTHER'S MAIDEN NAME MATTIE H. HAVAC
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-01-2027
17. INFORMANT MOTHER ADDRESS 617 N. MONTFORD AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE CIRCULATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 MIN
DUE TO
(B) CHRONIC RHEUMATIC HEART-ENLARGEMENT
DUE TO
(C) ~~NONE~~ CHILDHOOD RHEUMATIC INFECTION

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE	NONE	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO	NONE	NONE

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
NONE m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	NONE

22. *I hereby certify that I attended the deceased from* APRIL, 1949, *to* JULY 18, 1949, *that I last saw the deceased alive on* JULY 18, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles F. Avery M. D.	2722 E. Monument St.	July 18-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 21-1949	Oak Lawn Cem.	Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Keller ADDRESS: 1334 Jefferson St.

95B

G76386

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76386

Registered No.

1. NAME OF DECEASED (Type or Print): Stella M. Parsons

2. DATE OF DEATH: 7/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 937 Montpelier Street

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 937 Montpelier Street 9-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	6/14/1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	USA

13. FATHER'S NAME: John Gallagher

14. MOTHER'S MAIDEN NAME: Rose Lawn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Emory Parsons	937 Montpelier St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2½ hours

DUE TO

(B) Hypertensive-Arteriosclerotic Cardiovascular Disease — ?

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 17, 1949 *to* July 17, 1949 *that I last saw the deceased alive on* July 17, 1949, *and that death occurred at* 6:25 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William H. Fuseling M. D.	11 E. Chase St. Balto Md	July 16 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/21/49	Holy Redeemer Cem.	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 19 1949	Huntington Williams, M.D.	Lilly & Zeiler, Inc.	403 S. Wolfe St. (31)

VS 150

937

~~76387~~ 331 G76387

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Andrew Stewart Sr
2. DATE OF DEATH: July 19-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1830 E. Madison St
C. Length of stay in Baltimore: 20 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1830 E. Madison St 7-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Col.	Widowed	Aug. 20-08	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Beth. Steel	Woodward S. C.	U.S.A.

13. FATHER'S NAME: Andrew Stewart
14. MOTHER'S MAIDEN NAME: Rose Walley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Fashion William ADDRESS: 921 Washington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-19, 1949, to 7-19, 1949, *that I last saw the deceased alive on* 7-19, 1949, *and that death occurred at* 5⁰⁵ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leroy D. Young, M.D. M. D.	1113 N. Caroline Street	7-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 23-49	Mt. Calvery Cem.	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 19 1949	Huntington Williams M.D.	Elroy S. Wilson	1000 Brantly Ave

83a

G76388

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

334

Registered No. G76388

1. NAME OF DECEASED (Type or Print): KATHARINE DIETRICH SHRIVER

2. DATE OF DEATH: July 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 607 St. Paul St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 607 St. Paul St. 11-21

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Dec. 20, 1853	95 96				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Cincinnati, Ohio	

13. FATHER'S NAME: Clement Dietrich

14. MOTHER'S MAIDEN NAME: Katherine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Rosalia O. Shriver	607 St. Paul St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerosis, cerebral. — Interval between onset and death: 2 months

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B) Arteriosclerosis, generalized. — Several years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1949 *to* July 17th, 1949, *that I last saw the deceased alive on* July 11th, 1949, *and that death occurred at* 6:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward E. Chatard M. D.	1300 N. Calvert St. 2	7-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 20, 1949	Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 19 1949	Huntington Williams, M.D.	H. H. Mears and Son	805 N. Calvert St.

VS 150

97

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

Registered No. C76389

C76389
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Rebecca Amolsky

2. DATE OF DEATH July 19th 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 15 38

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 3714 Springdale Ave. Balto.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W.	Widowed	5.15.85	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk Home dry goods		Virginia	

13. FATHER'S NAME Gottlieb Bernstein

14. MOTHER'S MAIDEN NAME Freda ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		May Bernstein	2729 W Grace St Richmond Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Colon.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypertensive, Arteriosclerotic C.V.D.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7.14.49		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from July 12th, 1949, to July 19th, 1949, that I last saw the deceased alive on July 19th, 1949, and that death occurred at 12.15 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. J. Castellano M. D.	Bon Secours Hospital	July 19th 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 20/49	Oak Wood Cemetery	Richmond Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 19 1949	Huntington Williams, M.D.	Sol Levinson Bros	1126 N North ave

VS 150

46E

76390 m. 126919

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G78390 Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Inloes

2. DATE OF DEATH: 7-19-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 610 N. East Ave. Z 5 26-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	M	Nov. 30- 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10B. KIND OF BUSINESS OR INDUSTRY: War Plant

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph (D) Inloes

14. MOTHER'S MAIDEN NAME: Sarah Rolle (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-01-4375

17. INFORMANT: Records B.C.H. ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of left Lung with Probable Cerebral Metastases

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2- 15- , 1949 *to* 7- 19- , 1949 *that I last saw the deceased alive on* 7- 19- 1949 *and that death occurred at* 9.50 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE: G. A. Rozen M. D.

23B. ADDRESS: B.C.H. 4940 Eastern Ave.

23C. DATE SIGNED: 7-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE: July 22nd 1949

24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery

24D. LOCATION (City, town, or county) (State): O'Donnell Street

DATE RECEIVED BY LOCAL REGISTRAR: JUL 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Frederick D. Miller, Inc. ADDRESS: 3019 E. Monument St

VS 150

47D

6391

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76391

1. NAME OF DECEASED (Type or Print): JOHN P. WOERNER

2. DATE OF DEATH: 7-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 529 W. HAMBURG ST
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 21-01
D. STREET ADDRESS (If rural, give location): 529 W. HAMBURG ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	WIDOWED	6-1-1866	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CABINET MAKER.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: JOHN WOERNER
14. MOTHER'S MAIDEN NAME: UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ROBERT E. WOERNER ADDRESS: 529 W. HAMBURG ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Hypertensive cardio renal disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(C) —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/15, 1949, to 7/17, 1949, *that I last saw the deceased alive on* 7/16, 1949, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry Deiler M. D.
23B. ADDRESS: 1226 Harper St.
23C. DATE SIGNED: 7/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 7-20-49
24C. NAME OF CEMETERY OR CREMATORY: CEDAR HILL
24D. LOCATION (City, town, or county) (State): RITCHIE HIGHWAY, MD

DATE RECEIVED BY LOCAL REGISTRAR: JUL 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: JOHN F. DENNY, INC. ADDRESS: 715 LIGHT ST -30

VS 150

1310

76392

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450 Registered No. G76392

1. NAME OF DECEASED (Type or Print): Albert D. Darby

2. DATE OF DEATH: July 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5109 Ardmore Way

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5109 Ardmore Way 27-01

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan. 22, 1868
9. AGE (In years last birthday): 81 — If under 1 Year: Months / Days — If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman - retired
10B. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Darius Darby
14. MOTHER'S MAIDEN NAME: Catherine Mantz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Helen D. Orban — ADDRESS: 2507 Chelsea Terrace

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 20 years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1945 to July 18, 1949, that I last saw the deceased alive on July 18, 1949, and that death occurred at 11:50 P.m., from the causes and on the date stated above.

23A. SIGNATURE: Harry Lachman M. D.
23B. ADDRESS: 2 Wm Callon ave
23C. DATE SIGNED: July 19, 49

24A. BURIAL, CREMATION, REMOVAL (Specify): removal
24B. DATE: July 21, 1949
24C. NAME OF CEMETERY OR CREMATORY: Greenhill Cemetery
24D. LOCATION (City, town or county) (State): Martinsburg, West Virginia

DATE RECEIVED BY LOCAL REGISTRAR: JUL 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook, Inc., 1217 St. Paul Street — ADDRESS

VS 150

97

CERTIFICATE CORRECTED 7-20-49

G76393 GM. 130379 BALTIMORE CITY HEALTH DEPARTMENT 490 G76393

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) T. Walter Gray

2. DATE OF DEATH 7-18- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 47 YRS. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 747 McHenry ST. 21-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	July 30 -1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		VA.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
(D)	(D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Records B.C.H. 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Lobar Pneumonia- Right Lower Lobe	
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7- 17- , 19 49, *to* 7- 18- , 19 49 *that I last saw the deceased alive on* 7- 18-19 49 *and that death occurred at* 8.25 AM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. L. Rogers M. D.	B.C.H. 4940 Eastern Ave.	7-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 21. 49	Meadow Ridge	Dorsey- Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 20 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St Paul St.

VS 150

108 V

76594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76594 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry Jacobs

2. DATE OF DEATH: July 19 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Pa

B. COUNTY Halsted 6

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kenneth Sq.

c. Length of stay in Baltimore: Yrs. Mos. Days

B. STREET ADDRESS (If rural, give location): 124 S. Wood st

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 2-2-91

9. AGE (In years last birthday): 57 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): tailor

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Jacob Jacobs

14. MOTHER'S MAIDEN NAME: Anna Huda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hodgkins disease — INTERVAL BETWEEN ONSET AND DEATH: 4+ years

DUE TO

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 7/11/49 (Biopsy)

19B. MAJOR FINDINGS OF OPERATION: Hodgkins disease of axillary lymph node

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/9 1949 to 7/19 1949, *that I last saw the deceased alive on* 7/19 1949, *and that death occurred at* 1:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Frederick M. Holcomb M.D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 7/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 7-21-49

24C. NAME OF CEMETERY OR CREMATORY: Montefiore Cem

24D. LOCATION (City, town, or county) (State): Philadelphia, Pa

DATE RECEIVED BY LOCAL REGISTRAR: JUL 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Jack Lewis Inc

ADDRESS: 2100 Eutaw Pl

VS 150

44B

76395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76395 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN JACOB PAULUS

2. DATE OF DEATH July 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3633 Pulaski Highway

C. Length of stay in Baltimore 4 yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3633 PulaskiHighway 2-6-44

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	3-11-1889	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Helwig & Leitch Co.	Baltimore, Md.	U.S

13. FATHER'S NAME Paul Paulus

14. MOTHER'S MAIDEN NAME Rose Wieland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-01-3004

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE For Dr. Wm. H. Kammer, Jr. M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED July 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 20, 1949

24C. NAME OF CEMETERY OR CREMATORY Western

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 20 1949

REGISTRAR'S SIGNATURE Investigator Williams, M.D.

25. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS

VS 151

94a

G76396

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76396

1. NAME OF DECEASED (Type or Print): Annie Ford

2. DATE OF DEATH: 7/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1023 S. Howard Street

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1023 S. Howard Street 53-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colorer	Widowed	8/31/1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md	

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: Henrietta Dudley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mildred Bowen	1023 S. Howard St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARDIAC FAILURE

DUE TO

(B) ARTERIOSCLEROTIC + HYPERTENSIVE CARDIO-VASCULAR RENAL DISEASE

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/16, 1949 *to* 7/17, 1949 *that I last saw the deceased alive on* 7/16, 1949 *and that death occurred at* 11-30P *m. from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
I. Sharofsky M.D. M. D.	601 N. Monroe St.	7/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/20/49	Mount Auburn Ct.,	Baltimore, City.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 20 1949	Huntington Williams, M.D.	J. L. Brown & Son	108 W. Montgomery St

VS 150

431a

Claudia B-Lewis

6397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76397

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Claudia B Lewis

2. DATE OF DEATH July-17-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore 33 Yrs. Mons. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 505 S. Scott Street 21-01

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb 1-1889
9. AGE (In years last birthday) 60
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Dorchester Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Samuel Meekins
14. MOTHER'S MAIDEN NAME Rebecca Tyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. No.
17. INFORMANT Alonza F. Lewis - 2646 W. Lafayette ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebro-Vascular Accident
DUE TO
(B) Hypertensive C-V Disease
DUE TO
(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-11, 1949, *to* 7-17, 1949 *that I last saw the deceased alive on* 7-12, 1949, *and that death occurred at* 7:55 P m., *from the causes and on the date stated above.*

23A. SIGNATURE John A. Hightower M. D.
23B. ADDRESS University Hospital
23C. DATE SIGNED 7-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 21-49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem
24D. LOCATION (City, town, or county) (State) Balto Md
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR JUL 20 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR F. B. Shepherd & Son
1300 Eutaw

VS 150

61

76398

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

57 — 76398 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Isabel M. Elder. | 2. DATE OF DEATH July 18 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL
c. Length of stay in Baltimore 41 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY Fredricic
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sabillasville
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Married.		60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	State Employed	Maryland.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George S. Goodrich.	Anna Dahl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of pancrease with Liver metastisis and biliary obstruction.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary TBc-healed- Tubercule bacilli found in peritoneal fluid.

INTERVAL BETWEEN ONSET AND DEATH: 6 mo?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐
NONE		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1949, *to* July 18, 1949, *that I last saw the deceased alive on* July 18, 1949, *and that death occurred at* 8:45 A m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H Patterson Mack M. D.	University Hospital	July 18 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 21/1949	Loudon Park	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 20 1949	Twinetta Lee Williams, M.D.	Fred H. Ode 2000 Lombard St

VS 150

469

G76399

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76399

Registered No.

1. NAME OF DECEASED (Type or Print): Annie Clara Rooney

2. DATE OF DEATH: July 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 831 W. Fayette

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. 45 years Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 831 W. Fayette St. 16-01

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept. 17, 1869
9. AGE (In years last birthday): 79 80
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chesterfield co. Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Hansan
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:

17. INFORMANT: Daughter's
ADDRESS: 831 W. Fayette St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia
DUE TO
(B) Cerebral Hemorrhage
DUE TO
(C) Hypertension

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 16, 1949 *to* July 17, 1949 *that I last saw the deceased alive on* July 17, 1949 *and that death occurred at* 11:20 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Harry Kelmenson M. D.
23B. ADDRESS: 1308 Eutaw Place
23C. DATE SIGNED: July 17, 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: July 20 1949
24C. NAME OF CEMETERY OR CREMATORY: Moreland Memorial Park,
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUL 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Frederick A. Cole
ADDRESS: 1200 W. Fayette St.

VS 150

83a

~~76400~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76400

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Diederich

2. DATE OF DEATH: July 19 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3234 Kingsley St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 84 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3234 Kingsley St 20-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	Nov 19 1864	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Alma Mnfg Co	Balto Md	

13. FATHER'S NAME: John Diederich

14. MOTHER'S MAIDEN NAME: Mary Spangenberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mary D. Crook — ADDRESS: 3234 Kingsley St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

(B) Carcinoma of Rectum — 3 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 19 July 19 49 *to* 19 July 19 49, *that I last saw the deceased alive on* 18 July 19 49, *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward L. J. Kurey M. D.	4508 Edmondson Village	19 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 22 1949	New Cathedral	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 20 1949	Huntington Williams, M.D.	Harry J. Thomas	1204 Ridgewood Ave

VS 150

461

G76401

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 17 5

G76401

Registered No.

1. NAME OF DECEASED (Type or Print) MRS. Tillie PEPKA

2. DATE OF DEATH July 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS Hospital

c. Length of stay in Baltimore 36 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 331 So. CHESTER St. 1-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	MARRIED	11-7-06	42	8 / 11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Poland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WALTER JAKUBIK UNKNOWN

14. MOTHER'S MAIDEN NAME ALICE MIODUSZEWSKA UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT JOHN PEPKA ADDRESS 331 S. CHESTER ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Papillary Carcinoma of Ovary — INTERVAL BETWEEN ONSET AND DEATH 8 mos.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 7-6-49

19B. MAJOR FINDINGS OF OPERATION Generalized Careinomatosis

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-2 *, 19*49 *to* 7-17 *, 19*49 *that I last saw the deceased alive on* 7-17 *, 19*49 *and that death occurred at* 6 3/4 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Richard C Hayden M.D.

23B. ADDRESS Bon Secours Hosp

23C. DATE SIGNED 7-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, ~~town,~~ or county)	(State)
BURIAL	JULY 21, 1949	HOLY ROSARY	BALTIMORE	MD.

DATE RECEIVED BY LOCAL REGISTRAR JUL 20 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR M. F. SADOWSKI & SONS ADDRESS 1808 EASTERN AVE.

VS 150

49a

G76402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 4.1

G76402 Registered No.

BIRTH NO. B.C. 49-09478

1. NAME OF DECEASED (Type or Print): ERIC JONES

2. DATE OF DEATH: July 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2919 Spellman Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	S	May 8, 1949		2			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Milton Jones

14. MOTHER'S MAIDEN NAME: Etta Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Milton Jones ADDRESS: 2919 Spellman Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pulmonary edema

DUE TO

(B) Acute congestive cardiac failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: July 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-21-49	Mt. Auburn Cem	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Mrs. Frances A. Remsley 578 W. Fiddi

VS 151

1110

76403
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76403
Registered No.

1. NAME OF DECEASED (Type or Print): John BROWN

2. DATE OF DEATH: July 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 19 N. Eden St (E. W.)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	S	11-25-97	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Stephen Brown
14. MOTHER'S MAIDEN NAME: Annie Williams
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Carrie White 635 Cumberland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-sclerotic - C. V. D.
DUE TO
(B) Disease -
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: July 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): B.
24B. DATE: 7-20-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Byron & Minnie W. Wright 721 Aisquith St.

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76404 — Registered No. G76404

1. NAME OF DECEASED (Type or Print): John (McNeal) MCNAIR mp — 2. DATE OF DEATH: July 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 710 W. Fayette St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	Single	July 8, 19[illegible]	31		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Roland, S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John McNair
14. MOTHER'S MAIDEN NAME: Jacinda McNair

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Elizabeth Davis — ADDRESS: 710 W. Fayette St

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute gastritis

DUE TO

(B) Acute alcoholism

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 17 Jul 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/20/1949	Mt. Calvary	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 20 1949
REGISTRAR'S SIGNATURE: [signature] for Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Holland Funeral Home, 1631 Druid Hill Ave

VS 151

G76405

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

EP 16 1 G76405 Registered No.

1. NAME OF DECEASED (Type or Print): Frank F. Martins N-966

2. DATE OF DEATH: July 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland St. Agnes Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Ludlow, Mass.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	Oct. 10, 1924	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Ludlow, Mass.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Annibal Martins

14. MOTHER'S MAIDEN NAME: Gloria Fereira

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Mr. Martins, Ludlow, Massachusetts

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Ruptured of Duodenum DUODENUM	
	DUE TO (B) Ruptured Rt Kidney Bilateral fractured Femurs FEMUR	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION Howard Co.

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): public -- road

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Route #1, Savage, at intersection of Gorman Rd. & Wash. Blvd.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 16, 1949 5 P. m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Auto. & Tractor-trailer collided (Deceased passenger)

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 17 Jul 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 20 1949

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State): Springfield Mass

DATE RECEIVED BY LOCAL REGISTRAR: JUL 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Leo B. Leoch 170 S. Patterson Park Ave 170C

VS 151

G76406

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 857. G76406 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Stamboni (Sr.) N-86r.r

2. DATE OF DEATH: July 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6-03 43 N. Patterson Park Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	May 9. 1914.	35		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stevedore
10B. KIND OF BUSINESS OR INDUSTRY: Stevedore
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Louis Stamboni
14. MOTHER'S MAIDEN NAME: Mary Zuzzaro
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Butch. Stamboni ADDRESS: 43 N. Patterson Park

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Crushed chest, with
DUE TO atelectasis of right lung.
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): waterfront
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 300 Water St. Janks's Stevedore Corporation 4/1
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 16, 1949 ? m.
21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Struck by swinging object

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Thos. G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: July 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 26 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cy
24D. LOCATION (City, town, or county) (State): Belair Road
DATE RECEIVED BY LOCAL REGISTRAR: JUL 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Kendall Keppel ADDRESS: 313 Highland Ave

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BIRTH NO. G76407

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76407

1. NAME OF DECEASED (Type or Print): Viola Clark

2. DATE OF DEATH: July 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University

c. Length of stay in Baltimore: 21 yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 737 W. Fayette St. 657 W. Saratoga

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 11/17/15
9. AGE (In years last birthday): 33
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Smithfield, Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Clark
14. MOTHER'S MAIDEN NAME: Emma Ward

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Georgia Edwards
ADDRESS: 657 W. Saratoga

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection and Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/21/49
24C. NAME OF CEMETERY OR CREMATORY: Mount Calvary
24D. LOCATION (City, town, or county) (State): Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 20 1949
REGISTRATION DISTRICT: Williams, M
25. FUNERAL DIRECTOR: H. Halstead
ADDRESS: 918 Druid Hill Ave

VS 151

13B

G76408

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3 1

G76408

Registered No.

1. NAME OF DECEASED (Type or Print): MAGGIE BUTLER

2. DATE OF DEATH: July 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1833 Brunt Street

c. Length of stay in Baltimore: 35 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1833 Brunt Street 14-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Married	May 12, 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House-wife		Middlesex County, Va.	

13. FATHER'S NAME: Charles Lomax

14. MOTHER'S MAIDEN NAME: Fannie Ruffin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Wm. Butler - 1833 Brunt St-17 (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I (A)	Cerebral accident	
DUE TO (B)	Hypertension	
DUE TO (C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 4, 1949 *to* July 19, 1949 *that I last saw the deceased alive on* July 19, 1949 *and that death occurred at* 10:30a *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Julius L. White M. D.	1802 Penna ave	7-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/23/49	Henry's Hill	Belair, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 20 1949	Washington Williams, M.D.	A. HALSTEAD -918 Druid Hill Ave-1

83a

BIRTH NO. G76409

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. G76409 Registered No.

1. NAME OF DECEASED (Type or Print): ALOYSIUS J. WALSH

2. DATE OF DEATH: 7/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 503 East 20th Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 503 East 20th Street 9-08

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 18'77
9. AGE (In years last birthday): 72
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Compositor
10B. KIND OF BUSINESS OR INDUSTRY: News & Post
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Patrick Walsh
14. MOTHER'S MAIDEN NAME: Bridget E. Molloy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Rev. Eugene Walsh ADDRESS: 503 E. 20th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 12 hours

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-16, 1949, to 7-17, 1949 *that I last saw the deceased alive on* 7-16, 1949, *and that death occurred at* 5:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. D. Lynn M. D.
23B. ADDRESS: 11 E. Chase St.
23C. DATE SIGNED: 7-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/20/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): City

DATE RECEIVED BY LOCAL REGISTRAR: JUL 20 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: WIEDEFELD & SON
ADDRESS: GREENMOUNT AVE & 22ND

VS 150

94a

G76410 | BALTIMORE CITY HEALTH DEPARTMENT | G76410

BIRTH NO. | CERTIFICATE OF DEATH | Registered No.

1. NAME OF DECEASED (Type or Print): Carl P. Cicone

2. DATE OF DEATH: 18 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4610 Eastern Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4610 Eastern Ave 76-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Married	March 4 1895	54	4	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tavern [illegible]		Italy	U.S.

13. FATHER'S NAME: Antonio Cicone

14. MOTHER'S MAIDEN NAME: Chiarina Scoppitti

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Dora Maria Cicone ADDRESS: 4610 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 18 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 21st 1949	Holy Redeemer Cem.	4430 Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 20 1949
REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: Frank Della Rose ADDRESS: 322 S. High St.

VS 151

94a

6411 Bureau #8 ✓ X E 9-7-8 676411

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) DALTON R. ERICKSON — N-990.

2. DATE OF DEATH June 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Found in harbor off of Pier #4 Pratt St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE North Carolina
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Durham
D. STREET ADDRESS (If rural, give location) 3711 Roxboro Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 1 day: Hours	Min.
M	W			50?.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Drowning — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A). STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ ~~CAUSE OF~~ DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	harbor	Found: Harbor off of Pier #4, Pratt St

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐	NOT WHILE AT WORK ☒	21F. HOW DID INJURY OCCUR?
Found: June 8, 1949 9p m.			Undetermined

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George L. Merrill M.D.		June 9m 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		PUBLIC CEMETERY JUL 1 51949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 20 1949	Huntington Williams, M.D.	Commissioner of Health	

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G76412 G76412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Roy Hampton

2. DATE OF DEATH: July 19 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Vienna
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	Colored		9-22-13	35		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor		Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Eugene Hampton	Addie Morton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure
DUE TO
(B) Cerebral anoxia
DUE TO
(C) Congenital heart disease — Hypertensive cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Birth - 8 yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/16/49	Patent ductus arteriosus; cardiac hypertrophy	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/8, 1949, to 7/19, 1949, *that I last saw the deceased alive on* 7/19, 1949, *and that death occurred at* 9:00 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter L. Nelson M. D.	JOHNS HOPKINS HOSPITAL	7/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 22-49	Son + Daughters Cem.	Vienna Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 20 1949	Huntington Williams, M.D.	Elroy O. Wilson	1000 Brantly Ave

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76413 B.C. 49-14472 — Registered No. 776 G76413

1. NAME OF DECEASED (Type or Print): Baby Pierson

2. DATE OF DEATH: 7/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellicott City
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Single	7/18/49		2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Willie Pierson
14. MOTHER'S MAIDEN NAME: Mollie Perry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Wm. Pierson — ADDRESS: Ellicott City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity
DUE TO wt 13 oz.

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-18-49 *to* 7-20, 1949 *that I last saw the deceased alive on* 7-20, 1949, *and that death occurred at* 1:50 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Lydia M. Stamm M. D. | 23B. ADDRESS: St. Agnes' Hosp | 23C. DATE SIGNED: 7-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 7/21/49 | 24C. NAME OF CEMETERY OR CREMATORY: Baptist Church Cem. | 24D. LOCATION (City, town, or county) (State): Lisbon Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 20 1949 | REGISTRAR'S SIGNATURE: Tunstington Williams M.D. | 25. FUNERAL DIRECTOR: Easton Sons | ADDRESS: Ellicott City Md.

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G76414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

G76414

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY McBETH

2. DATE OF DEATH July 19,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 659 Dumbarton Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 70 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-1
D. STREET ADDRESS (If rural, give location) 659 Dumbarton Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	June 29,1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Charwoman - Retired	A. S. Abell Co.	Vienna, Austria	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Daniel Lorenz	Johanna Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Charles A. McBeth	659 Dumbarton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Sigmoid, — INTERVAL BETWEEN ONSET AND DEATH: 8 mo

DUE TO

(B) Metastasis to liver complete

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 19, 1948, *to* July 19, 1949, *that I last saw the deceased alive on* July 19, 1949, *and that death occurred at* 1 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S S A Stevens M. D.	2816 Hartford Rd	7-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 22,1949	Holy Cross Cem.	A. A. Co. Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Winston Williams, MD	William Cook, Inc.	1217 St. Paul St.

VS 150

46E

GM. 129349
G76415

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

57 G76415 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Vogel

2. DATE OF DEATH: 7- 20- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-06
D. STREET ADDRESS (If rural, give location): 1423 Gregor Way Z 24

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Sep.	June 7- 1891	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD.	

13. FATHER'S NAME: William Vogel

14. MOTHER'S MAIDEN NAME: Isabelle ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		B.C.H. Records	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Carcinoma of Pancreas with extension to Diaphragm And Liver, and tocommon Duct with Obstruction of Bile Flow

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
4- 26- 1949	Carcinoma Of Pancreas	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6- 1- 49, 1949, *to* 7- 20-, 1949, *that I last saw the deceased alive on* 7- 20 1949, *and that death occurred at* 3.00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
P. S. Rogers M. D.	B.C.H. 4940 Eastern Ave.	7- 20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/22/49	St Peters	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Huntington Williams, MD	Wm Cook Inc	1217 St Paul St

VS 150

469

G76416

CERTIFICATE CORRECTED 7-25-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76416

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Riedel, Mr. Earl

2. DATE OF DEATH: 7-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-42
D. STREET ADDRESS (If rural, give location): 3102 Lavor Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	August 5 1889	59	11	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maintainance Man		Maryland	U.S.A.

13. FATHER'S NAME: Riedel Christopher

14. MOTHER'S MAIDEN NAME: Lichner, Matilda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Son	2318 Arbutus Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of bladder — INTERVAL BETWEEN ONSET AND DEATH: 8 most

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June 30, 1949	Cancer of Bladder	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 1949 19__, *to* July 20, 1949 *that I last saw the deceased alive on* July 20, 1949 *and that death occurred at* 11:15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ronald L. Heaton M. D.	Church Home & Hospital	July 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/23/49	Meadow Ridge	Hervey Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Washington Williams, M.D.	Wm Cook Co.	1217 St Paul St.

VS 150

52 B

G76417 BALTIMORE CITY HEALTH DEPARTMENT 69-5 G76417

BIRTH NO. B.C. 49-11962 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): Baby Tyler

2. DATE OF DEATH: 6-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1320 Riggs Ave 16-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro		6-14-49			3 / 10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore	

13. FATHER'S NAME: Morris Tyler

14. MOTHER'S MAIDEN NAME: May Melzina Crockson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Toxemia of Pregnancy in Mother

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: hours 3 hrs.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Gilbert L. Banfield M. D.	722 N. Fulton Ave	6/15/49

24A. BURIAL, CREMATION OR REMOVAL	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Interment	6/16/49	Hoop Dreams	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 21 1949	Thurlington Williams, MD	

VS 150

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G76418 JL - 130291 BALTIMORE CITY HEALTH DEPARTMENT 776 G76418

BIRTH NO. BC.49-17682 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Baby Girl Reynolds- Mary

2. DATE OF DEATH 7-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) altimore

D. STREET ADDRESS (If rural, give location) 127 W. West St. 23-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	Negro	Single	July 13, 1949			1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
?	Mary Reynolds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		B. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Prematurity

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-13-49, 19__, *to* July 14, 1949, *that I last saw the deceased alive on* July 14, 1949, *and that death occurred at* 12.02AM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	4940 Eastern Ave.	7-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	7-16-49 at 9:00 A.M.	Balto. City Hospitals	4940 Eastern Ave. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 21 1949	Huntington Williams, MD	

VS 150

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G76419 ✓ Autopsy # 21899 G76419

BIRTH NO. B.C. 49-04780

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): BABY GIRL CROSS 751

2. DATE OF DEATH: JULY 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SYDENHAM HOSPITAL
C. Length of stay in Baltimore: Yrs. 4 hours Mos. 5 days Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: ~~EAST~~
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTIMORE 8-7
D. STREET ADDRESS (If rural, give location): 1636 EAST PRESTON ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	NEGRO	SINGLE	MARCH 7, 1949		4 / 5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: HAZEL CROSS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MOTHER ADDRESS: 1636 E. PRESTON ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) HYDROCEPHALUS — Interval between onset and death: 4 hours
DUE TO
(B) MENINGOMYELOCELE — 4 hours
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JULY 1, 1949 *to* JULY 9, 1949, *that I last saw the deceased alive on* July 8, 1949, *and that death occurred at* 12 21 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lahmer G. Yaney M. D.
23B. ADDRESS: Sydenham Hospital
23C. DATE SIGNED: July 9 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: July 9, 1949
24C. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Hospital
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS

VS 150

157a

G76420

BIRTH NO. 49-12511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168.0

G76420 Registered No.

1. NAME OF DECEASED (Type or Print): Rosie Marie Brown

2. DATE OF DEATH: 6-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: 1 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-2
D. STREET ADDRESS (If rural, give location): 1409 Madison Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Negro		6-21-49			1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME: William Brown

14. MOTHER'S MAIDEN NAME: Mabel Thorn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mother	1409 Madison Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonitis

DUE TO

(B) Dysticamia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6/21/49 6/22/49

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/21/49, 19__, to 6/22/49, 19__, *that I last saw the deceased alive on* 6/21/49 19__, *and that death occurred at* __ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. Bradshaw Hopkins M. D.	2243 Madison	6/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Hoy Disonal	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Huntington Williams, M.D.		

109a

G76421 BALTIMORE CITY HEALTH DEPARTMENT G76421

BIRTH NO. BC. 49-10910 CERTIFICATE OF DEATH 774 Registered No.

1. NAME OF DECEASED (Type or Print) Baby Malone 2. DATE OF DEATH 5/31/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

C. Length of stay in Baltimore Yrs. ~~Mos.~~ Days 25hrs

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore md
D. STREET ADDRESS (If rural, give location) 2227 Madison ave 13-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	N	Single	5/30/49			25hrs

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
N' Born		Baltimore md	

13. FATHER'S NAME Alexander Leonard Malone

14. MOTHER'S MAIDEN NAME Rebecca Curry 2227 Madison ave

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			Mrs Rebecca Malone	2227 Madison ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory Failure
DUE TO
(B) Weak Prematurity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 30, 1949, to May 31, 1949 *that I last saw the deceased alive on* May 31, 1949, *and that death occurred at* 7 am *m., from the causes and on the date stated above.*

23A. SIGNATURE N. Louise Jones M. D. | 23B. ADDRESS Provident Hospital | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY Hoss Desmond | 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 21 1949 | REGISTRAR'S SIGNATURE Huntington Williams, MD | 25. FUNERAL DIRECTOR | ADDRESS

VS 150

159

G76422

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

14

G76422

Registered No.

1. NAME OF DECEASED (Type or Print): Anna Somers

2. DATE OF DEATH: July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1701 Allamont St

C. Length of stay in Baltimore: 14 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-2
D. STREET ADDRESS (If rural, give location): 2011 Bolton St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1869
9. AGE (In years last birthday): 80
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lith
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Israel Berman

14. MOTHER'S MAIDEN NAME: Hennah Jaffe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Louis Geffrey
ADDRESS: 5200 ParkHeights Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 7

DUE TO

(B)

DUE TO

(C) N

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertrophic Arthritis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1942 *to* July 20 1949, *that I last saw the deceased alive on* July 20 1949, *and that death occurred at* 1235 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Joseph V. Blum M. D.
23B. ADDRESS: 1115 N. Calvert St
23C. DATE SIGNED: 7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 21, 1949
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run Cem
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

VS 150

1310

G76423

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT 94

CERTIFICATE OF DEATH

G76423 Registered No.

1. NAME OF DECEASED (Type or Print) JENNIE POLONSKY

2. DATE OF DEATH 7-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3908 No Rogers Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28-1

c. Length of stay in Baltimore 40 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 3908 No Rogers Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Widow		71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Russia	U.S.A.

13. FATHER'S NAME Dan

14. MOTHER'S MAIDEN NAME Freida

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Eva Lerner	3908 No Rogers

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Hypertension, Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 3yrs.
DUE TO → Arterio Sclerosis — 5yrs.
(B) Polycythemia Vera — 6mos.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1949 *to* July 20th 1949 *that I last saw the deceased alive on* July 20 1949 *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Michael A. Abrams M.D.	16 W Eutaw Place	July 21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-21-49	Mt Carmel	Old Fairmount Hall Rd Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Thurlington Williams M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

937

G76424 ✓ v. 1 G76424

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mr. Max Cohen
2. DATE OF DEATH: 7-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): AGED HOME
C. Length of stay in Baltimore: 65 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN: BALTO (If outside corporate limits, write RURAL and give township): 27-17
D. STREET ADDRESS (If rural, give location): GREENSPRING AVE

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOW
8. DATE OF BIRTH:
9. AGE (In years last birthday): 77 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: NOT KNOWN
14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: RAPHAEL COHEN ADDRESS: 2100 WILKENS AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriosclerotic cardio-vascular dis — several years
T.B. pulmonum.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-24, 1948, to 7-20, 1949, that I last saw the deceased alive on 7-20, 1949, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Jerome J. Blumberg M. D.
23B. ADDRESS: Levindale Home
23C. DATE SIGNED: 7-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 7-21-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949 VS 150
REGISTRAR'S SIGNATURE: Timothy for Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis, Inc. ADDRESS: 2100 Eutaw Pl.

13B

G76425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 914 Registered No. G76425

BIRTH NO.

N-991

1. NAME OF DECEASED (Type or Print): Lillian Dubinsky

2. DATE OF DEATH: July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3810 Fairview Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3810 Fairview Ave. 15-9

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept 23, 1912
9. AGE (In years last birthday): 36
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Perth Amboy N.J.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Siegel
14. MOTHER'S MAIDEN NAME: Ida

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Louis Dubinsky ADDRESS: 3810 Fairview Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation by hanging
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3810 Fairview Ave. Cellar
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 20, 1949 ? m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? (incellar) x Hanged self with clothes rope to pipe

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Geo. G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-21-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

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164a

G76426

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

410

G76426

Registered No.

1. NAME OF DECEASED (Type or Print): Elanor C. Placek

2. DATE OF DEATH: July 20 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 214 S. Chester St

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 2-1
D. STREET ADDRESS (If rural, give location): 214 S. Chester St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Mar. 27-1930	19				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Schoolgirl

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Wojciech Placek

14. MOTHER'S MAIDEN NAME: agnes Mazur

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: agnes Placek ADDRESS: 214 S. Chester St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO

(B) Mitral Insufficiency - Decompensating.

DUE TO

(C) Bronchial Hypertrophy

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1949 *to* July 20, 1949 *that I last saw the deceased alive on* July 19, 1949 *and that death occurred at* 7 9 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edward Humphreys M. D.

23B. ADDRESS: 2579 Eastern Av.

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 23-1949

24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. S. Fialkowski ADDRESS: 2007 Eastern Ave

VS 150

92.B

G76427 130348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

343 G76427 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Iola Jones

2. DATE OF DEATH 7- 16- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 30 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-36
D. STREET ADDRESS (If rural, give location) 5603 Crossbill CT. Z 24

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	Negro	Sep.	Dec. 15 1891	57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		N.C.	

13. FATHER'S NAME Tom Horton

14. MOTHER'S MAIDEN NAME Priscilla ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Records B lto. City Hospitals	4940 Eastern Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Hemorrhage Duration.	13 hrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Hypertensive Arteriosclerotic Cardio Vascular Disease Duration ?	
	DUE TO (C) Obesity Duration	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7- 16-, 1949 *to* 7- 16-, 1949, *that I last saw the deceased alive on* 7- 16- 1949, *and that death occurred at* 3.40 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. S. Rogers M. D.	B.C.H. 4940 Eastern Ave.	7-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	July 21, 1949	Mt Auburn	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Victor Williams, M.D.	Mrs Walter R Williams	3221 Sherwood Ave

937

G76428

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76428

Registered No.

1. NAME OF DECEASED (Type or Print): Sarah V. Brooks.

2. DATE OF DEATH: July 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1317 Madison Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1317 Madison Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 507 N. Carey St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 507 N. Carey St. 18-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	C	Widow.	January 10, 1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown.

14. MOTHER'S MAIDEN NAME: Hallett Heath

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Birdie Robinson. ADDRESS: 507 N. Carey St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular-Renal

DUE TO

(B) Disease - Arteriosclerotic, — INTERVAL BETWEEN ONSET AND DEATH: 1-2 years

DUE TO

(C) Uremia.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/2, 1949, *to* 7/17, 1949, *that I last saw the deceased alive on* 7/17, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. L. Jackson M.D.

23B. ADDRESS: 600 N. Arlington Ave.

23C. DATE SIGNED: 7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 21, 1949

24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. J. Peter R. Williams & Schweizer

ADDRESS

VS 150

131a

G76429

GM. 130108

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76429

1. NAME OF DECEASED (Type or Print): John Jackson

2. DATE OF DEATH: 7-17- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 40 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: 18-3
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 17 S. Schroder ST. (or Stroder ST.)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Widowed	March 5- 1874	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Calvin Jackson
14. MOTHER'S MAIDEN NAME: Millie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records B.C.H. ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pyelonephritis with ProbableUremia
DUE TO
(B) Anaplastic Carcinoma of bladder
DUE TO
(C) Gonorrheal Structure with Perneal Fistula

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
gonorrheal stricture c perineal fistula

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7- 5- 1949 *to* 7- 17- 1949, *that I last saw the deceased alive on* 7- 17-1949, *and that death occurred at* 7.40 PM *from the causes and on the date stated above.*

23A. SIGNATURE: A. S. Rozen M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 7-18- 194

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 21, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Rutter & Williams ADDRESS: Schroder St

VS 150

52B

G76430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 952

Registered No. G76430

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edna White N-861.2

2. DATE OF DEATH 7/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY A.A.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.P. South Baltimore General

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Harmans

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Negro	Married		46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Penna.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.

16. SOCIAL SECURITY NO.

17. INFORMANT Thomas White ADDRESS Harmans, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stab wound of Heart.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Mathewstown, Harmon Station, A.A. Co.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 7-16-49 8:12 P.M.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Sharp instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

23A. SIGNATURE Earl L. Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 7/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/21/49

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn

24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 21 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR A. Halstead ADDRESS 918 Eutaw St. Balto. Md. 167

VS 151

G76431

BIRTH NO. B.C. 49-14199

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 675

G76431 Registered No.

1. NAME OF DECEASED (Type or Print): CARL ELMER PAULMAN

2. DATE OF DEATH: 7-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: BALTIMORE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BON SECOURS HOSPITAL
c. Length of stay in Baltimore: Yrs. 10 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 20-2
D. STREET ADDRESS (If rural, give location): 50 N. GORMAN AVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	WHITE	SINGLE	7-10-49			10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		BALTIMORE, MD	USA

13. FATHER'S NAME: WILLIAM EDGAR PAULMAN

14. MOTHER'S MAIDEN NAME: MARGARET MARY SCHMUCK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO		

17. INFORMANT: MRS. WILLIAM PAULMAN ADDRESS: 50 N. GORMAN AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Premature Infant

DUE TO

(B) Atelectasis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 10, 1949, *to* July 20, 1949 *that I last saw the deceased alive on* July 20, 1949, *and that death occurred at* 3:00 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. Kinohler M. D.	Bon Secours Hosp.	7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	July 21/49	WOODLAWN	WOODLAWN Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Huntington Williams, M.D.	V. PHOUSE FUNERAL HOME	1216 S. CHARLES ST.

VS 150

159 30

G76432

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76432

Registered No.

1. NAME OF DECEASED (Type or Print) Katherine V. Zell

2. DATE OF DEATH. July 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2952 W. Mosher St.
c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 2952 W. Mosher St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-7
D. STREET ADDRESS (If rural, give location) 2952 W. Mosher St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	July 11, 1875	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Zell
14. MOTHER'S MAIDEN NAME Rose Ann Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs May E. Scott, ADDRESS 2952 W. Mosher St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Haemolitic Anemia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION none
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) none
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) no
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) none m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 14, 1948 *to* July 17, 1949 *that I last saw the deceased alive on* July 16 1949 *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Julius A Ostrand M. D.
23B. ADDRESS 1219 Eutaw Place
23C. DATE SIGNED July 20 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 21, 1949
24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR JUL 21 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Frederick A. Otto
ADDRESS 1000 W. Lanvale St.

VS 150

731

G76433

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E900.0 ✓ N-920.0

G76433
Registered No.

1. NAME OF DECEASED (Type or Print) LYDIA R. HADAWAY

2. DATE OF DEATH JULY 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL
C. Length of stay in Baltimore 7 Yrs. 9 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 21-2
D. STREET ADDRESS (If rural, give location) 1220 W. OSTEND ST. #30

5. SEX female
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH DEC-24-1873
9. AGE (In years last birthday) 75 76 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) BALTIMORE
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT SADIE MURPHY ADDRESS 1101 OSTEND ST BALT. MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) TERMINAL PNEUMONIA. — 5 Days.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CERTIFICATION APPROVED BY
G. A. Merrill M. D.
CORO OR ASST. MEDICAL EXAMINER.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. FRACTURED LEFT HIP. — 12 days.

19A. DATE OF OPERATION 7-11-49
19B. MAJOR FINDINGS OF OPERATION FRACTURED LEFT HIP
20. AUTOPSY? YES ☐ NO ☑
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) HOME
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1220 W. OSTEND ST.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 7-8-49 m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? SLIPPED DOWN STAIRS

22. *I hereby certify that I attended the deceased from* 7-8, 1949, *to* 7-20, 1949, *that I last saw the deceased alive on* 7-19, 1949, *and that death occurred at* 8:05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE R. E. Martin M. D.
23B. ADDRESS Maryland General Hosp
23C. DATE SIGNED 7-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 23, 1949
24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION (City, town, or county) (State) Baltimore
DATE RECEIVED BY LOCAL REGISTRAR JUL 21 1949
REGISTRAR'S SIGNATURE Turnbington Williams, M.D.
25. FUNERAL DIRECTOR Fred A. Cole
ADDRESS 1208 W Fayette St

VS 150

To be approved by Medical Examiner 186a

G76434

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ X 1 1 Registered No. G76434

1. NAME OF DECEASED (Type or Print) BLAIR LEE ROCHE

2. DATE OF DEATH July 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Halethorpe
D. STREET ADDRESS (If rural, give location) Waelchli Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white		Feb. 17, 1925	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Clinton Blair

14. MOTHER'S MAIDEN NAME Ruth Grimes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) war2 (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 219-18-8195

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute congestive cardiac failure.

DUE TO

(B) Probable heat prostration.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George A. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED July 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	July 21 1949	Meadowridge Park	Elkridge, Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 21 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25 FUNERAL DIRECTOR Fred A. Cole ADDRESS 2001 Lombard St

93E

G76435

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E903.4 G76435 Registered No.

N-821.0

1. NAME OF DECEASED (Type or Print): Mary Ruppal

2. DATE OF DEATH: July 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-3
D. STREET ADDRESS (If rural, give location): 62 S. Carrollton Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	W	May 20 1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Forsythe

14. MOTHER'S MAIDEN NAME: Minnie Ackerman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture Femur Bilateral — DUE TO — Middle 1/3 — INTERVAL BETWEEN ONSET AND DEATH: Days

(B) — DUE TO —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Possible Pulmonary Embolism — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Extreme Obesity — ?

CERTIFICATION APPROVED BY
G. H. Merrill
For: John R. Davis M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
18 July 49	closed reduction + hip spica	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident		Haintzman's Beach 54-05

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
11 July 49 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	fell on ice [illegible]

22. *I hereby certify that I attended the deceased from* 11 July, 19 49, *to* 19 July, 19 49, *that I last saw the deceased alive on* 19 July, 19 49, *and that death occurred at* 4:40 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	[illegible]	19 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	July 22, 1949	Mt. Olivet	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Huntington Williams, M.D.	Fred A. Cole	1220 W Lombard St

VS 150

186a

G76436

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33 2

G76436

Registered No.

1. NAME OF DECEASED (Type or Print): Elizabeth Wortman

2. DATE OF DEATH: July 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore, Md.
B. COUNTY: 1713 Wilkens Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1713 Wilkens Avenue

19-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	White	Widowed	Sept. 30, 1863	85				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home duties

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christian Weisman

14. MOTHER'S MAIDEN NAME: Mary Schleibacher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Leona Roden — ADDRESS: 1713 Wilkens Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure, cerebral

DUE TO

(B) thrombosis and generalized arteriosclerosis — Dec. 1948

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 27, 1948 *to* July 17, 1949 *that I last saw the deceased alive on* July 17, 1949 *and that death occurred at* 8.20 A. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Laura A Kemp M.D. — 23B. ADDRESS: 3030 Edmondson Avenue — 23C. DATE SIGNED: July 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 21, 1949	Loudon Park Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Frederick A. Cole, 1200 W. Lombard st.

VS 150

838

G76437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1/20

Registered No. G76437

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas M. Evans

2. DATE OF DEATH: July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-1
D. STREET ADDRESS (If rural, give location): 214 E. Pratt St.

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: Nov. 10, 1897 | 9. AGE (In years last birthday): 51 yrs. | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Jackson, Miss.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Evans

14. MOTHER'S MAIDEN NAME: Louise Marion

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes | (If yes, give war or dates of service): W. W. I

16. SOCIAL SECURITY NO.: 456-16-7567

17. INFORMANT: Mrs. Lip Burecis | ADDRESS: Jackson, Miss.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: July 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal | 24B. DATE: 7/21/49 | 24C. NAME OF CEMETERY OR CREMATORY: Greenwood Cem. | 24D. LOCATION (City, town, or county) (State): Jackson, Miss.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949 | REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS | ADDRESS: Balto., Md.

VS 151

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G76438

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 v. 1

G76438

Registered No.

1. NAME OF DECEASED (Type or Print): LEE JACKSON CULLUM.

2. DATE OF DEATH: JULY 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1632 N. WASHINGTON ST

c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 8-6
D. STREET ADDRESS (If rural, give location): 1632 N. WASHINGTON ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	W	MAY 6, 1860	89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
IRON MOLDER		BALTO. MD.	U.S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	no	Mrs. LEATHERBURY	SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CHRONIC MYOCARDITIS.

DUE TO

(B) ARTERIOSCLEROSIS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JULY 20 1949, *to* JULY 20, 1949, *that I last saw the deceased alive on* JULY 20 1949 *and that death occurred at* 11:45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry J. Houghton M. D.	333 S. East Ave.	7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/22/49	Oak Lawn Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

937

G76439 CERTIFICATE CORRECTED 7-25-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 v 0 1

BIRTH NO. Registered No. G76439

1. NAME OF DECEASED (Type or Print): Blanche Olivia Alexander

2. DATE OF DEATH: July 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3604 Hillsdale Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Anderson Nursing Home

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): ~~3600 Mohawk Ave~~ 3436 Mordanning Ave. 15-38

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	Sept. 3, 1886	62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Woodensburg, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Green	Emma Morrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Mrs. Margaret S. Anderson	3600 Mohawk Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

(B) Cerebral Thrombosis — 3 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 14 1949 *to* July 19, 1949, *that I last saw the deceased alive on* July 19 1949 *and that death occurred at* 2 05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Daniel Robinson M. D.	2835 Guilford Ave.	7/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 21, 1949	Mt. Gilead Woodensburg Md.	Woodensburg, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949		Wm. J. Tickner & Sons	North & Pa. Ave.

VS 150

94a

G76440

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76440

1. NAME OF DECEASED (Type or Print): ANNA EUGENIA LONG

2. DATE OF DEATH: July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3605 Hillsdale Rd.

Anderson Nursing Home

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2837 Woodbrook Ave. 13-4

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Aug. 9, 1875
9. AGE (In years last birthday): 73 yrs.
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Produce
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas W. Long
14. MOTHER'S MAIDEN NAME: Mary L. Booz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Mrs. William H. Long
ADDRESS: 6308 Bellona Ave. 12

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 1-49, 19__ *to* July 20/49, 19__, *that I last saw the deceased alive on* July 19/49, *and that death occurred at* 3-20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm. C. Stroud M. D.
23B. ADDRESS: 1929 Mount Ave
23C. DATE SIGNED: July 21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/22/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

937

G76441
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 ✓

G76441
Registered No.

1. NAME OF DECEASED (Type or Print) MARY Viola Hammett

2. DATE OF DEATH July 20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 23-2

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1507 Patapsco Street

C. Length of stay in Baltimore Life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1507 Patapsco Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	D.	Jan 6-1892	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sprayer & Packer	Nesco Co	Baltimore	U. S. A.

13. FATHER'S NAME Peter Slert

14. MOTHER'S MAIDEN NAME Julia Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	219-03-4162	Mrs Ruth Carey	1505 Patapsco St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis — 1 yr.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-19, 1949 *to* 7-20, 1949, *that I last saw the deceased alive on* 7-20 1949 *and that death occurred at* 12:20 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	707 Font Ave.	7-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 23-49	Cedar Hill Cem	A. A. Co.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	[signature]	Wm Cook Inc.	1217 St Paul St

VS 150

830

G76442
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76442

1. NAME OF DECEASED (Type or Print) MATILDA CHLOPICKI

2. DATE OF DEATH July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 130 S. PATTERSON PK AV
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. JOSEPH'S HOME FOR AGED
c. Length of stay in Baltimore 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Washington D.C.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Washington
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F	W.	Married	March 17 1874	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		Poland	U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Hosp. Records	130 S. Patterson Park Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) TERMINAL BRONCHO-PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

DUE TO

(B) CEREBRAL ARTERIOSCLEROSIS — SINCE 4/12/48

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) GENERALIZED ARTERIOSCLEROSIS — ???

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. BILATERAL CATARACTS — ??

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* APRIL 12, 1948 *to* JULY 21, 1949, *that I last saw the deceased alive on* JULY 21, 1949, *and that death occurred at* 4A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph F. Drenga M. D.	289 S. Charles St	7/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/23/49	Fort Lincoln	Prince George Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Huntington Williams, M.D.	W. W. Chambers Co.	Washington D.C.

VS 150

3 97

CERTIFICATE CORRECTED 8-8-49

G76443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Irva E. Shelley

2. DATE OF DEATH: July 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2310 W. Lanvale St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 2310 W. Lanvale St. 16-5

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: March 13, ~~1892~~ 1891
9. AGE (In years last birthday): ~~57~~ 58
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): clerk
10B. KIND OF BUSINESS OR INDUSTRY: New Amsterdam Cas.Co.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob F. Shelley
14. MOTHER'S MAIDEN NAME: Isabella Godfrey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Fannie I. Bieswanger ADDRESS: 2310 W.Lanvale

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 min

DUE TO

(B) Coronary Sclerosis — 4 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1, 1947, *to* July 19, 1949, *that I last saw the deceased alive on* July 19, 1949, *and that death occurred at* 9:30 Am. *from the causes and on the date stated above.*

23A. SIGNATURE: H. Mendelis M. D.
23B. ADDRESS: 651 N Bentalou
23C. DATE SIGNED: 7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 22, 1949
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemey.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John O. Mitchell Sons
ADDRESS: 1900 Eutaw Place

VS 150

94a

G76444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76444 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary J. Benson

2. DATE OF DEATH July 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1708 Eutaw Place

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmhurst Nursing Home

c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 27-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	white	single	Nov. 24, 1871	77 78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Balto. Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph B. Benson	Jane Mac Coy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Ann B. Hollingsorth	2800 Gibbons Ave.

MEDICAL CERTIFICATION

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) asthenia

DUE TO

(C) auricular fibrillation

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-18, 1949 *to* ____, 19__, *that I last saw the deceased alive on* 7-18, 1949, *and that death occurred at* 11:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bernard Burgin M. D. M. D.	6721 Reisterstown Rd.	9/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 21, 1949	Loudon Park Cemy.	Fred. Ave. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Huntington Williams, M.D.	John O. Mitchell & Sons	1900 Eutaw Place

VS 150

93D

G76445

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 193

G76445

Registered No.

1. NAME OF DECEASED (Type or Print): Deborah Harding

2. DATE OF DEATH: July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — N. Surg Hall

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-6
D. STREET ADDRESS (If rural, give location): 2523 W. North ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White		3-19-46	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Harold Harding

14. MOTHER'S MAIDEN NAME: Dorothea Johnston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial tumor (Malignant) — INTERVAL BETWEEN ONSET AND DEATH: 8 mos

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: May 1948

19B. MAJOR FINDINGS OF OPERATION: Tumor rt frontal lobe

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-2-, 1949 *to* 7-20-, 1949 *that I last saw the deceased alive on* 7-20-, 1949 *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Merrill L. Bitler M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 22 '49

24C. NAME OF CEMETERY OR CREMATORY: Jarrettsville, Md. Cem.

24D. LOCATION (City, town, or county) (State): Preston Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John O. Mitchell & Sons

ADDRESS: 1400 Eutaw Place

54 B

150

G76446

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76446

Registered No.

1. NAME OF DECEASED (Type or Print): LOUISE THALWITZER

2. DATE OF DEATH: 20 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore: 63 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore city 15-38
D. STREET ADDRESS (If rural, give location): 3405 Piedmont Av.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	S	1/19/68	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure; pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) cerebro vascular accident — 1 day

DUE TO

(C) arterio sclerotic cardio vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 19 July, 1949 to 20 July, 1949 *that I last saw the deceased alive on* 20 July 1949 *and that death occurred at* 8 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: L. Thal M. D.

23B. ADDRESS: Sinai Hospital Baltimore

23C. DATE SIGNED: 20 July '49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremate

24B. DATE: July 22/49

24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cemy

24D. LOCATION (City, town, or county) (State): Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: John D. Mitchell & Son

ADDRESS: 1900 937 Eutaw Place

VS 150

G76447

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

G76447

Registered No.

1. NAME OF DECEASED (Type or Print): Helen Gross

2. DATE OF DEATH: July 20th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland yes

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 200 Goodwood Gardens Baltimore 10

c. Length of stay in Baltimore: 15 → Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 200 Goodwood Gardens 27-14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	Feb 2nd 1870	79	5 / 18	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Harrisburg Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George A. Gross

14. MOTHER'S MAIDEN NAME: Mary Wingard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular Disease.

DUE TO

(B) Hypertension

DUE TO

(C) Hemi-plegia, R.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 10 years.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 20th 1949, *to* July 20th 1949, *that I last saw the deceased alive on* July 20, 1949, *and that death occurred at* 3:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: George A. Gross M. D.

23B. ADDRESS: 2947 St Paul St.

23C. DATE SIGNED: July 20th 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 22/49

24C. NAME OF CEMETERY OR CREMATORY:

24D. LOCATION (City, town, county) (State): Wilmington N.C.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949

REGISTRAR'S SIGNATURE: Tennyson Williams, M.D.

25. FUNERAL DIRECTOR: John A. Mitchell Sons

ADDRESS: 1900 Eutaw Place

937

VS 150

G76448

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 v° 1

Registered No. G76448

1. NAME OF DECEASED (Type or Print) Robert Harvey

2. DATE OF DEATH 7-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 17-1
D. STREET ADDRESS (If rural, give location) 536 Orchard St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	M	6/29/94	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fitter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Richmond, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mary Harvey — ADDRESS 536 Orchard Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Myocardial Infarction

DUE TO

(C) Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-14, 1949 to 7-19, 1949, *that I last saw the deceased alive on* 7-19, 1949, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. H. Smith M. D.	Univ. Hosp.	7-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/23/49	Mount Calvary	Cedar Hill, Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Charles L. Law — 802 Madison Ave

VS 150

94a

G76449

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76449

1. NAME OF DECEASED (Type or Print): Benjamin T. Towner Sr

2. DATE OF DEATH: July 19 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2801 Chelsea Terrace

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Penna.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westchester
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Jan 1 1873	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY: Dry Goods Mer.

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Towner

14. MOTHER'S MAIDEN NAME: Louise Deicher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Benjamin T. Towner Jr ADDRESS 3003 Rosalind Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage, Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C) Chronic Myocarditis + Nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

22A. SIGNATURE: Dr Thos J Abbott M. D.

23B. ADDRESS: 4509 Liberty Heights Ave

23C. DATE SIGNED: 7-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 22 1949

24C. NAME OF CEMETERY OR CREMATORY: Baltimore

24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949

REGISTRAR'S SIGNATURE: Winfield Scott Williams, M.D.

25. FUNERAL DIRECTOR: Henry H. Thomas

ADDRESS: 4204 Ridgewood Ave

VS 150

131a

~~copy for W.S.~~

76450

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E9000 G76450

Registered No.

1. NAME OF DECEASED (Type or Print) Alick W. Reeves Sr. — Negro | 2. DATE OF DEATH 7-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mer. Baltimore Gen. Hosp.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-7
D. STREET ADDRESS (If rural, give location) 2724 Hampden Ave #11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Widowed.	June 12, 1861	88				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	Horse Trainer	England.	

13. FATHER'S NAME: George Reeves

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	Mrs. Thomas I. Gill	2425 Denison St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
E. G. Mensel M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

DUE TO

(B) Fract. left femur, supt. of urethra

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

- with uremia & thrombosis of
ASCVD - Aur Fibrillation.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-11-49	Necrotic synovium	YES ☐ NO ☒

21A. ACCIDENT, ~~SUICIDE~~, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
6-21-49	Home	2724 Hampden Ave #11

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
6 21 49 9 p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Pt. fell down steps at home

22. *I hereby certify that I attended the deceased from* 6-22-49, 19__, *to* 7-19-49, 19__, *that I last saw the deceased alive on* 7-18-49, 19__, *and that death occurred at* 5 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bowie Linn Grant. M. D.	Mer. Baltimore Gen. Hosp.	7-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
Burial	7/22/49	Woodlawn Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Huntington Williams, M.D.	WM. J. TICHNER & SONS	Balto., Md.

VS 150

186a

G76451
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E81 v. 4

Registered No. G76451

1. NAME OF DECEASED (Type or Print): HERMAN Schook N-804-0

2. DATE OF DEATH: July 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. city

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Essex
D. STREET ADDRESS (If rural, give location): 501 Riverside Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	5/12/86	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tool-maker

10B. KIND OF BUSINESS OR INDUSTRY: Aircraft

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Mathew Schook

14. MOTHER'S MAIDEN NAME: Claira Turnbaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 186-14-1973

17. INFORMANT: Caroline Schook ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Contusion of brain.
DUE TO
(B) Intracranial Hemorrhage
DUE TO
(C) Fractured skull

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Fractured leg, fractured pelvis, arteriosclerosis, diabetes

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Eastern Ave. and Taylor Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 14, 1949 9 p. m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: George B. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [X]
ASSISTANT MEDICAL EXAMINER [ ]
MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 7-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	July 24-49	Pongert Manor	Sunbury Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: J. J. Brzezenski ADDRESS: 1407 Eastern Ave.

VS 151

170C

G76452

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

470 1

G76452

Registered No.

1. NAME OF DECEASED (Type or Print) Charles E. Stanley

2. DATE OF DEATH July 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1209 E Monument St

c. Length of stay in Baltimore Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5-1
D. STREET ADDRESS (If rural, give location) 1209 E Monument St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Married	April 28, 1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
News Stand Operator		Baltimore Md	

13. FATHER'S NAME
Edward Stanley

14. MOTHER'S MAIDEN NAME
Ella Lenox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT — ADDRESS
Emma Stanley 1209 E Monument

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Myocarditis

DUE TO

(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/14, 1949 *to* 7/18, 1949, *that I last saw the deceased alive on* 7/18, 1949, *and that death occurred at* 10:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas L Lafont M. D.	822 N. Bond St	7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 22/49	Mt Auburn Cem.	Westport Md

DATE RECEIVED BY LOCAL REGISTRAR
JUL 21 1949

REGISTRAR'S SIGNATURE
Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS
Mr. Robt. A. Elliott Dyster — 93D 1129 N Carlton St

VS 150

G76453 ✓ G76453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

774 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Baby Boy Davina

2. DATE OF DEATH 7/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24-4
D. STREET ADDRESS (If rural, give location) 1510 Battery Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		7/12/49			8

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore Md.	

13. FATHER'S NAME
William Davina

14. MOTHER'S MAIDEN NAME
Mildred Hoffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH: 8 DAYS
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. IMPETIGO NEONATORUM — 8 DAYS

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/12, 1949 *to* 7/20, 1949, *that I last saw the deceased alive on* 7/21, 1949, *and that death occurred at* 3155 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Samuel P. Scalia M. D.	So. Baltimore Gen. Hosp.	7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	July 21-1949	Edenhill	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Waiting for Williams, M.D.	Flynn & Fleming	1426 Light St.

VS 150

159

G76454

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76454

1. NAME OF DECEASED (Type or Print): JENNIE JOHNSON

2. DATE OF DEATH: 18 July 49 6PM

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Hosp 27 N. Carey St

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 14-3
D. STREET ADDRESS (If rural, give location): Mc Cullough St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow	July 10, 1875	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas B. Carter
14. MOTHER'S MAIDEN NAME: Margaret Bowen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Not
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Margaret Sanders — ADDRESS: 1925 Dinwiddie Ct

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease with cardiac degeneration and decompensation

DUE TO

(B) Hypostatic pneumonia

DUE TO

(C) Chronic hypertrophic arthritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bullous Impetigo

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 25 June, 1949 *to* 18 July, 1949, *that I last saw the deceased alive on* 18 July, 1949, *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Emil H. Stenning Jr. M. D. — 23B. ADDRESS: 4580 Edmondson Ave — 23C. DATE SIGNED: 19 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: July 22, 1949 — 24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Pk. — 24D. LOCATION (City, town or county) (State): Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Hallgarth Funeral Home — ADDRESS: 1631 Dinwiddie Ct 931

VS 150

G76455

JL - 129794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 3

G76455

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Isaac Richardson

2. DATE OF DEATH 7-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1425 Winchester St. 16-2

5. SEX M

6. COLOR or RACE Negro

7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) Single

8. DATE OF BIRTH Mar. 4, 1880

9. AGE (In years last birthday) 69
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Isaac Richardson

14. MOTHER'S MAIDEN NAME Mary Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Md.

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS B. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION July15, 1949

19B. MAJOR FINDINGS OF OPERATION Gastric Resection

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-20, 1949, *to* July 18, 1949 *that I last saw the deceased alive on* July 18 1949, *and that death occurred at* 3.55 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE C. S. Cozen M. D.

23B. ADDRESS 4940 Eastern Ave.

23C. DATE SIGNED July 19,49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/20/1949

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 21 1949

REGISTRAR'S SIGNATURE Mrs. Agnes Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Holland Funeral Home 1631 Druid Hill Ave. 83B

VS 150

G76456

G76456

BIRTH NO. G76456

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 151

1. NAME OF DECEASED (Type or Print): Joseph Jamison

2. DATE OF DEATH: 7-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-2
D. STREET ADDRESS (If rural, give location): 1511 McCulloh St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Dec. 26, 1905	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur		Fairfax, S.C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Jamison	Sarah Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Flossie L. Jamison	1511 McCulloh St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Pneumothorax Aneurism of descending Arch of Aorta Compression of Great vessel

(B) DUE TO: Embolism Vena Cava Syndidine

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____ 19__ *to* 7-18 , 1949, *that I last saw the deceased alive on* 7-14- , 1949, *and that death occurred at* 4.45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. C. Brady Jr. M. D.	Provident Hosp	7-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 21, 1949	Family Lot	Fairfax, S.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Lurlington Williams, M.D.	Holland Funeral Home	1601 Druid Hill Ave.

VS 150

30D

Correct age is especially important if deceased was under 1 year or 100 years or more

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76457 — Registered No. G76457

1. NAME OF DECEASED (Type or Print): Margaret Mullikin — 2. DATE OF DEATH: JUL 20 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 6 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md — B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Essex
D. STREET ADDRESS (If rural, give location): 611 Eastern Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	10-9-79	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md	

13. FATHER'S NAME: David Ringrove

14. MOTHER'S MAIDEN NAME: Clarabelle Sluck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

(B) Hypertensive arteriosclerotic

DUE TO

(C) heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-13- 1949 *to* 7-20 1949 *that I last saw the deceased alive on* 7-20 1949 *and that death occurred at* 5:20 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William W. Winternitz M. D.	JOHNS HOPKINS HOSPITAL	7-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/22/49	Mt. Cathedral	Frederick Rd. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Lucretia Williams, M.D.	John D Connolly.	Essex 21, Md.

VS 150

93D

CERTIFICATE CORRECTED 7-26-49

G76458

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6 ✓

Registered No. G76458

1. NAME OF DECEASED (Type or Print) Thomas Chonkich (TOCA CHONKITZ) 2. DATE OF DEATH 7/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 239 S. Calhoun St

c. Length of stay in Baltimore 40 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 19-3

D. STREET ADDRESS (If rural, give location) 239 S. Calhoun St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	May 9 1883	66 64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Blacksmith Helper	B & O. R.R.	Yugoslavia	Yugoslavia

13. FATHER'S NAME Paul Chonkich

14. MOTHER'S MAIDEN NAME Lecksa Plavsin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		108-03947	Eva Chonkich	239 South Calhoun St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) carcinoma left lung — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
May 10, 1949	Bronchogenic carcinoma left lung.	YES ☐ NO ✓

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 18, 1949, *to* July 20, 1949, *that I last saw the deceased alive on* July 20, 1949, *and that death occurred at* 9 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathan Raevain M. D.	206 S. Gilmor St.	7.21.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/23/49	Loudon Park	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR
JUL 21 1949	Courtenay for Williams, M.D.	Bell & B. M. Walter Funeral Directors

VS 150

47c

G76459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G76459

1. NAME OF DECEASED (Type or Print): Mary E Seidel

2. DATE OF DEATH: July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1242 Light St
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-3
D. STREET ADDRESS (If rural, give location): 1242 Light St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Nov 28, 1874	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cleaning & Dyeing	Self employed	Balto	U.S.

13. FATHER'S NAME: John W. Snyder

14. MOTHER'S MAIDEN NAME: Emma Abbey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	No	William J. Seidel	2-14 ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cardiac Hypertrophy — 1 yr.

DUE TO

(C) Cardiac Dilatation

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1948 *to* July 20, 1949, *that I last saw the deceased alive on* July 20, 1949, *and that death occurred at* 5:30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Vincent M. Messina M. D.	1403 St Charles St	7/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 23	Loudon Pk	Balto City Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Huntington Williams, M.D.	A. Garnet Evans	1402 St Charles St

VS 150

937

Please write clearly. Physician's correct age is especially important.

GM. 103523
G76460

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76460
Registered No.

1. NAME OF DECEASED (Type or Print): Casper Poltz

2. DATE OF DEATH: 7- 20- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: 2-1
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2020 E. Lombard ST.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 15 1876
9. AGE (In years last birthday): 72 (?) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: labor
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Poltz
14. MOTHER'S MAIDEN NAME: Mary ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: B.C.H. Records 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia.
DUE TO
(B) Cardio Arteriosclerotic Vascular Disease
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Paralysis ~~Agitans~~ Agitans

INTERVAL BETWEEN ONSET AND DEATH: (over)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-6- , 19 46 *to* 7- 20- , 19 49 *that I last saw the deceased alive on* 7- 20- 19 49 *, and that death occurred at* 2.15 AM. *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Rogers M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 7-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 22-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): 4600 Belair Rd. Balto

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949
REGISTRAR'S SIGNATURE: Timothy for Williams, Mgr.
25. FUNERAL DIRECTOR: Deppel Bro ADDRESS: 1800 E Lombard St

VS 150

937

Dr. Battaglia

BIRTH NO. 26461 Belair

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 076461

1. NAME OF DECEASED (Type or Print): John Martin Seidel

2. DATE OF DEATH: July 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4439 Belair Road

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-2
D. STREET ADDRESS (If rural, give location): 4439 Belair Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	June 19, 1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John K. Seidel

14. MOTHER'S MAIDEN NAME: Kunigunda Neubauer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Catherine Seidel, ADDRESS: 4439 Belair Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

DUE TO: Chronic

(B) Diabetes mellitus — 3 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/15, 1949 *to* 7/20, 1949 *that I last saw the deceased alive on* 7/18, 1949 *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: D. T. Battaglia M. D.

23B. ADDRESS: 5829 Belair Rd.

23C. DATE SIGNED: July 20 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 7-23-49

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 21 1949

REGISTRAR'S SIGNATURE: Turlington Williams, M.D.

25. FUNERAL DIRECTOR: Leonard J. Ruck, ADDRESS: 5305 Harford Road.

VS 150

61

G76462

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

585

Registered No. G76462

1. NAME OF DECEASED (Type or Print) JACOB JENSEN

2. DATE OF DEATH 7-20-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-3
d. STREET ADDRESS (If rural, give location) 5012 Catalpa Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, (MARRIED) WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	White		May 3, 1882	67	—	-	—	-

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Solicitor

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Denmark

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Christian Jensen

14. MOTHER'S MAIDEN NAME Annie Simonsen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT Wife ADDRESS (same)

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PANCREATITIS — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) CHOLECYSTITIS —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) —

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ASHD —

19A. DATE OF OPERATION 5-17-49

19B. MAJOR FINDINGS OF OPERATION — University Md. Hospital

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 30, 1949 *to* July 20, 1949, *that I last saw the deceased alive on* July 20, 1949, *and that death occurred at* 3 — m., *from the causes and on the date stated above.*

23A. SIGNATURE Richard R. Bebek M. D.

23B. ADDRESS Union Memorial Hosp.

23C. DATE SIGNED 7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7-23-49

24C. NAME OF CEMETERY OR CREMATORY Parkwood

24D. LOCATION (City, town, or county) Balto Md (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 21 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR Leonard J. Ruck ADDRESS 5305 Harford

VS 150

93D

G76463

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

G76463

Registered No.

1. NAME OF DECEASED (Type or Print): MARY LEE ROYAL SHONKWILER

2. DATE OF DEATH: 7/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-7
D. STREET ADDRESS (If rural, give location): 1607 North Hilton St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W		6/19/1890	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School teacher - retired	Teaching	Rome, Indiana	

13. FATHER'S NAME: Howard Malcolm Royal

14. MOTHER'S MAIDEN NAME: Mary Hannah Batson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Ada Lee Schonkwiler	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral vascular accident. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive cardio-vascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/15, 1949, *to* 7/21, 1949, *that I last saw the deceased alive on* 7/21, 1949, *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Arlyn V. Wood M. D.	West Balt. General Hosp.	7/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/23/49		Tell City, Ind.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 21 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

937

Please write plainly. Physician, please write the exact age if especially important.

G76464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G76464

1. NAME OF DECEASED (Type or Print) CHARLES J. MARX, Sr.

2. DATE OF DEATH July 20th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Pine Ridge Convalescent Home

C. Length of stay in Baltimore 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fullerton, Md.
D. STREET ADDRESS (If rural, give location) Buck School House Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	widower	Feb. 20th, 1868	81	5			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Farmer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Marx

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mr. Fred Marx ADDRESS 7 Glade Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO

(B) Probable Cancer, urinary bladder ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis — Years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 4, 1949 *to* July 20, 1949, *that I last saw the deceased alive on* July 18, 1949, *and that death occurred at* 10.40 p m., *from the causes and on the date stated above.*

23A. SIGNATURE Charles V. Sewell M. D.

23B. ADDRESS 11 W Chase St

23C. DATE SIGNED 7/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial

24B. DATE 7/23/49

24C. NAME OF CEMETERY OR CREMATORY Parkwood

24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1949

REGISTRAR'S SIGNATURE Twington Williams, M.D.

25. FUNERAL DIRECTOR Lassahn Funeral Home ADDRESS 7401 Belair Rd.

VS 150

528

G76465

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

81 Registered No. G76465

1. NAME OF DECEASED (Type or Print) **Frederick Robbins**

2. DATE OF DEATH **July 20/49**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **Balto. Md.**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Elmhurst Nursing Home**
c. Length of stay in Baltimore **30dys** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Back River Neck Rd.** B. COUNTY **Balto. Co.**
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Back River Md.**
D. STREET ADDRESS (If rural, give location) **Back River Neck Rd.**

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	---	----	65yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Lowes Poultry Farm	Balto. Md.	

13. FATHER'S NAME **Unknown**

14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-- --	----	Mrs.C.W.Lowe,	Back River Neck Rd. Balto. Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized carcinomatosis

DUE TO

(B) Caranoma Bladder

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 11 1949 *to* July 20, 1949 *that I last saw the deceased alive on* July 20, 1949 *and that death occurred at* 3P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis Jacobs, M.D. M. D.	1700 Eutaw Place (17)	July 21-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 22/49	Mt. Carmel Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Williams, M.D.	Philips Herring Sons	2024 Orleans St.

VS 150

52B

G76466

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1

G76466

Registered No.

1. NAME OF DECEASED (Type or Print): ALFORD C. PORTS

2. DATE OF DEATH: JULY 19 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST AGNES HOSPITAL

c. Length of stay in Baltimore: 57 YRS (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 25 - 43
D. STREET ADDRESS (If rural, give location): 1912 GRINNALDS AVENUE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	WHITE	MARRIED	DEC. 2, 1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER	BALTO. TRANS. CO.	BALTIMORE, MARYLAND	U.S.A.

13. FATHER'S NAME: WM. A. PORTS

14. MOTHER'S MAIDEN NAME: MARGARET DRIVER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	W.W. I		MARY M. PORTS	1912 GRINNALDS AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Thrombosis	2 Hours
DUE TO		
(B)	Arteriosclerosis	5 years?
DUE TO		
(C)	Erythromelalgic Syndrome	30 years?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 3, 1947, *to* July 19, 1949, *that I last saw the deceased alive on* July 19, 1949, *and that death occurred at* 8:30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathan Rosenberg M. D.	2411 Washington Blvd.	7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	JULY 22, 1949	BALTIMORE NATIONAL	BALTIMORE, MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Nottingham, M.D.	WM COOK INC.	1217 ST PAUL ST.

VS 150

94a

G76467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74 Registered No. G76467

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Esther Apple

2. DATE OF DEATH July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3502 Reisterstown Road

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3502 Reisterstown Road 15-IV

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Married	May 12, 1898	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
House Wife		Baltimore	Md	USA

13. FATHER'S NAME: Morris Harris

14. MOTHER'S MAIDEN NAME: Fannie Richardson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Oscar Apple	Reisterstown Road 3502

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Uterus with Metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 years (?)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2/1/48; 1/20/49

19B. MAJOR FINDINGS OF OPERATION Carcinoma of Uterus

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1949 *to* 7-21, 1949, *that I last saw the deceased alive on* 7-7, 1949, *and that death occurred at* 4.50A m., *from the causes and on the date stated above.*

23A. SIGNATURE A. A. Brooman M. D.

23B. ADDRESS 1109 N. Calvert St

23C. DATE SIGNED 7-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 22, 1949

24C. NAME OF CEMETERY OR CREMATORY Bnai Israel Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Sol Levinson & Bros

ADDRESS 1126 W North Ave

VS 150

48B

G76468

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63

G76468

Registered No.

1. NAME OF DECEASED (Type or Print) ABRAHAM POLOWAY

2. DATE OF DEATH 7-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 321 So Fmallwood St

c. Length of stay in Baltimore 58 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-05
D. STREET ADDRESS (If rural, give location) 321 So Fmallwood St

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH
9. AGE (In years last birthday) 80 If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Not Known

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Leo Poloway ADDRESS 321 So Fmallwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of rt lung — INTERVAL BETWEEN ONSET AND DEATH 8 mos
DUE TO

(B)
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Carcinoma (metastatic) of rt lung — 3 mos

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/1 *, 19* 49 *, to* 7/21 *, 19* 49 *, that I last saw the deceased alive on* 7/17 *, 19* 49 *, and that death occurred at* 7 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE Benjamin Miller M. D.
23B. ADDRESS 2030 Wilkens Ave
23C. DATE SIGNED 7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-22-49
24C. NAME OF CEMETERY OR CREMATORY United Hebrew
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eastern Ave

VS 150

47)

G76469

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

20-01

Registered No. G76469

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Oliver F. Michaux, Sr.

2. DATE OF DEATH: July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1852 W. Fayette St. N.E. Cor. Fayette & Monroe St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Divorced	July 8, 1888	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Journeyman	Barber	Belgium	Unknown

13. FATHER'S NAME: Martin Michaux

14. MOTHER'S MAIDEN NAME: Adele Gerrard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Oliver F. Michaux, Jr. ADDRESS: R. F. D. #2 Verona, Pa.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Carl L. Rogers M.D.		July 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/22/49	Plum Creek	Plum Townslife, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Williams, MD	WM. COOK, INC.	1217 St. Paul St.

VS 151

94a

Please write clearly and legibly. Physician's special attention is especially important.

G76470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76470

Registered No.

BIRTH NO. B.C. 49-14450

1. NAME OF DECEASED (Type or Print): Baby Boy Weaver 776

2. DATE OF DEATH: 7-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Gen Hosp

C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5418 Belair Road 27-34

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	W	Single	7-14-49			6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Maryland	U.S.

13. FATHER'S NAME: Walter Lee WEAVER

14. MOTHER'S MAIDEN NAME: Florence Leota Sweet

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

(B) Premature Separation Placenta

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
None m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5:30 Pm 7-14, 1949 *to* 11:30 Pm 7-14, 1949 *that I last saw the deceased alive on* 8 Pm 1949 *and that death occurred at* 11:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
Walter C. Fuller	Maryland Gen Hosp	7/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
		UNIVERSITY MEDICAL SCHOOL	JUL 20 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Registrar for Baltimore, Md	Commissioner of Health	

VS 150

160c

G76471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76471 Registered No.

BIRTH NO. B.C. 49-14803

1. NAME OF DECEASED (Type or Print) BABY BOY ANDREWS

2. DATE OF DEATH July 15 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1610 Bolton St. 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		7/15/49			4 / 5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Sylvester Andrews

14. MOTHER'S MAIDEN NAME Joyce Chapman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity
DUE TO premature birth

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/15, 1949 *to* 7/15, 1949 *that I last saw the deceased alive on* 7/15, 1949 *and that death occurred at* 8:45 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE D. H. MacPherson M. D.

23B. ADDRESS So. Baltimore Gen'l. Hosp.

23C. DATE SIGNED 7/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State) JUL 20 1949

DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS

VS 150

159

G76472

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76472 Registered No.

1. NAME OF DECEASED (Type or Print): Miller, Clara

2. DATE OF DEATH: 7/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: 1519 Division St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: 57 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 890 Linden Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Negro	Widowed	Apr 15, 1892	57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	-	Baltimore, Md	

13. FATHER'S NAME: Sharpsburg Starks

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinomatosis	
ANTECEDENT CAUSES	DUE TO (B) Carcinoma of Cervix	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Intestinal Obstruction	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 1948	Carcinoma of the cervix	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/12/49 *to* 7/19/49, *that I last saw the deceased alive on* 7/19, 19 49 *and that death occurred at* 10:25 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr Marcus W. Moore Sr M. D.	Provident Hospital	7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-23-49	Arlington Mem Pk	Baltimore Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Williams, M.D.	Mrs Francis A. Hunsby & W. Biddle	348

VS 150

48a

G764473

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G764473 Registered No.

1. NAME OF DECEASED (Type or Print) LUCY TALBOT

2. DATE OF DEATH July 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1127 Myrtle Avenue

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1127 Myrtle Avenue 17-0

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH
9. AGE (In years last birthday): 80 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Lauderdale
14. MOTHER'S MAIDEN NAME: Margaret Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. C. Jones ADDRESS 1426 E. Madison

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE George S. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED July 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-22-49
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn
24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1949
REGISTRAR'S SIGNATURE Hunter for Williams, Mgr
25. FUNERAL DIRECTOR Mrs. Frances A. Henderson & Biddle ADDRESS 716

VS 151

937

Please write the cause of death clearly and in ink. Physician's special attention is especially important. Physician please write the correct age is especially important.

G76474

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76474

1. NAME OF DECEASED (Type or Print): George Raymond Williams

2. DATE OF DEATH: July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
c. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 862 W. Lemmon St. 1803

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	3/17/1903	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Junk Dealer	Self	Baltimore Md	U S A

13. FATHER'S NAME: Charles Williams

14. MOTHER'S MAIDEN NAME: Mary E. Brogan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Mary E. Williams ADDRESS: 862 Lemmon St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: July 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/23/49	Schwartz Cem.	O'Donnell St

DATE RECEIVED BY LOCAL REGISTRAR: JUL 22 1949

REGISTRAR'S SIGNATURE: Funeraltor Williams, M.D.

25. FUNERAL DIRECTOR: John J. Cowen & Son ADDRESS: 2[illegible]

VS 151

13B

Please write the cause of death clearly and legibly. Physician please write the correct age is especially important.

G76475

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

600

G76475

Registered No.

1. NAME OF DECEASED (Type or Print) Matilda Hinke

2. DATE OF DEATH July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 64 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 508 N. Belnord 7-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Married	1-19-85	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME Paul Paulsen.

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 5 days.

DUE TO

(B) Acute Pyelonephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Coronary Arteriosclerosis, Cardiac Hypertrophy

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7-16 1949 *to* 7-20, 1949, *that I last saw the deceased alive on* 7-20 1949, *and that death occurred at* 7:12 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jack M. Burnett M. D.	JOHNS HOPKINS HOSPITAL	7/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 23/49	Holy Redeemer Cem.	Belair Rd. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 22 1949	Huntington Williams, M.D.	John A. Keller 2334 Jefferson St.

VS 150

95c

Please use this space for death entry and be especially important. Physician please write clearly and correct age is especially important.

G76476 BR. 96616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

143 G76476

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Anton Hylschel

2. DATE OF DEATH 7- 9- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 74 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) No Home 26-12.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	S	June 11- 1870	79				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Austria	

13. FATHER'S NAME Theodore Hylschel

14. MOTHER'S MAIDEN NAME Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: Records B.C.H. 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive Arteriosclerotic Cardio-Vascular Disease.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10- 11- , 1945, *to* July 9- , 1949, *that I last saw the deceased alive on* 7- 9- 1949, *and that death occurred at* 1 .15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. L. Bozen M. D.	B.C.H. 4940 Eastern Ave.	7- 21- 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	JUL 21 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

939

Correct age is especially important. Physician please write the cause of death clearly and legibly.

G76477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 3

G76477

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print) JOHN BLUME

2. DATE OF DEATH 7/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSP.

c. Length of stay in Baltimore 7 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 109 S. CONKLING ST 76-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	WIDOWED	Nov	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CEMENT FINISHER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) GERMANY

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT JOHN BLUME, JR ADDRESS SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diffuse peritonitis — INTERVAL BETWEEN ONSET AND DEATH: D.O.A.

DUE TO

(B) Perforated diverticulum of sigmoid

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Diverticulosis & diverticulitis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Adenocarcinoma of sigmoid Hubert evidence in path

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

CERTIFICATION APPROVED BY
G. H. Merrill M.D.
For: Wm. G. Helfrich M. D.
CHIEF OR ASST. MEDICAL EXAMINER

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE Paul G. Hensel M. D. | 23B. ADDRESS Maryland General Hosp | 23C. DATE SIGNED 7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 23, 1949	Holy Redeemer Cem	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John A. Moran ADDRESS 3000 E Balto St

To be approved by medical examiner's office 46E Balto. 24 md

VS 150

Please write the cause of death clearly and legibly. Physician please correct age is especially important.

G76478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4218

Registered No. G76478

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HOWARD N. BLIGHT Jr

2. DATE OF DEATH July 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 6009 HARFORD Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 6009 HARFORD B. COUNTY BALTO Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO. Md.
D. STREET ADDRESS (If rural, give location) 6009 HARFORD ROAD 27-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	WHITE	MARRIED	3-25-01	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FUNERAL DIRECTOR

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) BALTIMORE

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME HOWARD N. BLIGHT, Sr

14. MOTHER'S MAIDEN NAME CORA HILTZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service) NONE

16. SOCIAL SECURITY NO. —NONE

17. INFORMANT Mildred T. Blight ADDRESS BALTO Md

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary occlusion	
DUE TO		
ANTECEDENT CAUSES	(B) Malignant hypertensive C.V.R.D.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Diabetes Mellitus	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1949 *to* July, 1949, *that I last saw the deceased alive on* July 19, 1949, *and that death occurred at* 1 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M.D.	4218 Harford Rd	7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	July 25, 1949	PARKWOOD	TAYLOR Ave BALTO Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Williams, M.D.	Mildred T. Blight	6009 Harford Rd Balto 14. Md

61

Please write the cause of death clearly and legibly. Physician's signature is especially important. Physician's address and date of signature must be correct.

G76479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-1-4

G76479

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Campbell M. Hicks

2. DATE OF DEATH July 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1330 N. Mount Street

c. Length of stay in Baltimore — Yrs. Life time Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1330 N. Mount Street

15-0Y

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Married	9/14/1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	

13. FATHER'S NAME: Richard H. Hicks

14. MOTHER'S MAIDEN NAME: Alice Hicks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Dorthy Hicks	1330 N. Mount St., Balt', Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 7

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-1, 1949 *to* 7-18, 1949 *that I last saw the deceased alive on* 7-18, 1949 *and that death occurred at* 9.20 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles T. Mallet M. D.	861 Park Ave	7-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 22, 1949	Arbutus Memorial Park	Arbutus, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Williams, M.D.	Joseph L. Russ	1200 McCulloh St.

VS 150

937

Be sure age is especially important. Physician please write clearly and legibly.

G76480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

133.1

G76480 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANCES MAY

2. DATE OF DEATH 7/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hosp.

c. Length of stay in Baltimore 12 Yrs. Mos.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Balto. B. COUNTY Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24-04
D. STREET ADDRESS (If rural, give location) 1817 Westphal Place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year, last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Apr. 10. 1915	34		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Camden, N. J.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George H. Kraemer

14. MOTHER'S MAIDEN NAME Frances M. Hart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-14-9524

17. INFORMANT Hospital Records ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolism

DUE TO

(B) Chronic heart disease with irregular rhythm

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/20, 1949 to 7/20, 1949 *that I last saw the deceased alive on* 7/20, 1949 *and that death occurred at* 10:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE Thaddeus Zawacki M. D.

23B. ADDRESS St. Joseph's Hosp

23C. DATE SIGNED 7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 23. 49

24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.

24D. LOCATION (City, town, or county) (State) A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Flynn & Fleming ADDRESS 1426 Light St.

937

VS 150

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G76481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

G76481

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Stanislaus J Kosinski

2. DATE OF DEATH July 21 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 125 N. MONTFORD Ave

c. Length of stay in Baltimore 50 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6 - O

D. STREET ADDRESS (If rural, give location) 125 N. Montford Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widower	May 7 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Labor	Poland	Poland

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	212-14-0862	Mrs Theresa Howell	125 N. Montford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO

(B) Carcinoma of Bowel — 1 year

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/14/49, 19__, *to* 7/21/49, 19__, *that I last saw the deceased alive on* 7/20/49 19__, *and that death occurred at* 5:00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Max Baum M. D.	1501 N. Milton Ave	7/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/25/49	Holy Rosary Cem	Balto. County

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Williams, MD	John M. Weber	401 S. Chester St

VS 150

46E

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76482

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Greigler

2. DATE OF DEATH: July 19, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 7072 Dolphin St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 7072 Dolphin St.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 7072 Dolphin St.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 7072 Dolphin St. 17-03

5. SEX: male
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug 26, 1892
9. AGE (In years last birthday): 56 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Post Office

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Rev. Daniel Greigler.
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Yes W.War I
16. SOCIAL SECURITY NO.: 215-24-4143
17. INFORMANT: Mildred Greigler ADDRESS: 7072 Dolphin St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatous growth Bladder — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO and bowel Rectal
(B) Carcinoma Prostate — unknown
DUE TO
(C) none

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Aug 1948
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Prostate
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE? (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1948 *to* July 19, 1949, *that I last saw the deceased alive on* July 19, 1949, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ralph J. Young M. D.
23B. ADDRESS: 1424 E. Monument St
23C. DATE SIGNED: 7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-22-1949
24C. NAME OF CEMETERY OR CREMATORY: National Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams
ADDRESS: 322 N

VS 150

51B

G76483
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76483

1. NAME OF DECEASED (Type or Print): AGNES HART

2. DATE OF DEATH: 7-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1447 ANDRE ST
c. Length of stay in Baltimore: 56 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 24-01
D. STREET ADDRESS (If rural, give location): 1447 ANDRE ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	MARRIED	12-25-1892	56	6			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	BALTIMORE	U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO	NO	—

17. INFORMANT: Richard Hart ADDRESS: 1447 Andre St.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician please write especially important. Exact age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive C.V. Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs. / with Cerebral Accident — 7 hrs

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1949, to 7/19, 1949, *that I last saw the deceased alive on* 7/19, 1949, *and that death occurred at* 8 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	102 E. West St.	7/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-23-49	Holy Cross	U.A. Co.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Tuttle for Williams, M.D.	Charles L. Hill	1501 E. Fort Ave

VS 150

93D

G76484

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76484

Registered No.

1. NAME OF DECEASED (Type or Print): BESSIE M. CHAMBERS

2. DATE OF DEATH: July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Crawford Retreat 2117 Dennison St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): formerly of 4312 Maine Ave. 28 02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Aug. 4, 1876	72 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore, Md.	

13. FATHER'S NAME: John Henry Watson

14. MOTHER'S MAIDEN NAME: Sarah J. Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Mr. John C. Watson	332 Rossiter Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B)

DUE TO

(C) Arteriosclerotic Cardiovascular Disease. Uncertain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Senility

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 20, 1949 *to* July 20, 1949, *that I last saw the deceased alive on* July 20, 1949, *and that death occurred at* 9:20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joshua H. Amacott M. D.	6419 Windsor Mill Rd	July 22 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	7/23/49	Woodlawn Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS.	Balto., Md.

VS 150

93D

Please write the cause of death clearly and legibly. Physician: please write the exact age if especially important.

G76485

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76485

Registered No.

1. NAME OF DECEASED (Type or Print): Marion C. Talley

2. DATE OF DEATH: July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Fla.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lakeland
D. STREET ADDRESS (If rural, give location): 1918 Seminole Trail

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	married	Dec. 7, 1891	57 Years				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Owner	Theatre chain	Columbia, S. C.	

13. FATHER'S NAME: Razwell T. Talley

14. MOTHER'S MAIDEN NAME: Isaetta C. Coles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

Write the cause of death clearly and legibly. Physician please write the correct age is especially important.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diffuse Encephalomalacia — INTERVAL BETWEEN ONSET AND DEATH: 1 Month

DUE TO

(B) Cerebral Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

old myocardial infarction

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7-21, 1949 *to* 7-21, 1949 *that I last saw the deceased alive on* 7-21, 1949, *and that death occurred at* 5:20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John M. Burnett, M. D.	JOHNS HOPKINS HOSPITAL	July 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/22/49		Lakeland, Fla.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

83c

G76486

G76486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) William Ross Henderson

2. DATE OF DEATH July 21 - 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 4302 Westwood Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 25 years. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE COUNTY 4302 Westwood Road
B. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore-7. Md
C. STREET ADDRESS (If rural, give location) 25-07

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH May 24- 1873 | 9. AGE (In years last birthday) 76 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Saltillo. Pa | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME T. Remick Henderson

14. MOTHER'S MAIDEN NAME M. Minnie Doyle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ✓ (If yes, give war or dates of service) ✓ | 16. SOCIAL SECURITY NO. ✓

17. INFORMANT Mrs Douglas Longenecker ADDRESS 4304 Westwood Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 min

DUE TO

ANTECEDENT CAUSES

(B) Cardio Vascular Disease — ?

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 25, 1949 *to* July 20, 1949 *that I last saw the deceased alive on* July 20, 1949, *and that death occurred at* 5.50 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE Charles F. Warner, M. D. | 23B. ADDRESS 421 Med. Arts Bldg | 23C. DATE SIGNED 7/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7/25/49 | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | 24D. LOCATION (City, town, or county) (State) Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Wm. J. Pickney & Sons | ADDRESS Balto, Md.

VS 150

93D

Please write in the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G76487

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

156.1 G76487

Registered No.

1. NAME OF DECEASED (Type or Print): MARY A. CHELF

2. DATE OF DEATH: July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 510 E. 20th St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 510 E. 20th St. 9-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	Feb. 2, 1869	80 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Baltimore, Md.	

13. FATHER'S NAME: John Schone

14. MOTHER'S MAIDEN NAME: Bridget Flaherty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-	-	Mr. Irving F. Chelf	510 E. 20th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA, LIVER — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROSIS

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 27, 1949, *to* July 20, 1949, *that I last saw the deceased alive on* July 19, 1949, *and that death occurred at* 12 45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles V. Sewell M. D.	1 W. Aurelia Ave	7/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/22/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Thurlington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

46F

Please write plainly. Physician: please write to the cause of death clearly and fully. Exact age is especially important.

BIRTH NO. G76488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76488

1. NAME OF DECEASED (Type or Print): Mary Kilgo

2. DATE OF DEATH: July - 19- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 526 W. West St.

c. Length of stay in Baltimore: 8 Yrs. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

D. STREET ADDRESS (If rural, give location): 526 W. West St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col.	Widow	Sept. 10. 1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Calvert Co. Md.	U.S.A.

13. FATHER'S NAME: John Hutchins

14. MOTHER'S MAIDEN NAME: Duzella Hutihins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
NO		Mary Newman 526 W. West St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure

DUE TO

(B) Arteriosclerotic + hypertensive

DUE TO Cardiovascular renal disease

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1949, to July 18, 1949, *that I last saw the deceased alive on* July 18, 1949, *and that death occurred at* 5:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Shrofel, M.D. M. D.	601 N. Howard St	7/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 29, 49	Mt Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JUL 22 1949	Huntington Williams, MD	Elroy C. Wilson 1000 Brantly Ave.

4-S 150

131a

Please write the cause of death clearly and legibly. Physician's signature is especially important. Please correct age if necessary.

G76489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$50.00

G76489

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) MOSES GREEN

2. DATE OF DEATH July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
805 S. Hanover St.

c. Length of stay in Baltimore All Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 805 S. Hanover Street 22-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	Widower	Aug. 20, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Produce Handler		Baltimore Md.	U.S.A.

13. FATHER'S NAME Perry Green

14. MOTHER'S MAIDEN NAME Alice Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Eva Banks	1112 W. Sartago St.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made for the cause of death clearly and legibly. Do not use abbreviations or symbols. Do not state the mode of dying, such as heart failure, asphyxia, anemia, or uremia, without stating the primary cause which produced it. Indefinite or unsatisfactory terms, such as "senility," "old age," "debility," "exhaustion," "cardiac arrest," "pneumonia," "bronchitis," "tuberculosis," "cancer," "paralysis," "convulsions," "hemorrhage," "shock," "uremia," "blood poisoning," "septicemia," "pyemia," "abscess," "gangrene," "ulcer," "tumor," "accident," "fracture," "injury," "operation," "malpractice," "homicide," "suicide," are not sufficient. Physician please write the cause of death clearly and legibly. Do not use abbreviations or symbols. Do not state the mode of dying, such as heart failure, asphyxia, anemia, or uremia, without stating the primary cause which produced it. Indefinite or unsatisfactory terms, such as "senility," "old age," "debility," "exhaustion," "cardiac arrest," "pneumonia," "bronchitis," "tuberculosis," "cancer," "paralysis," "convulsions," "hemorrhage," "shock," "uremia," "blood poisoning," "septicemia," "pyemia," "abscess," "gangrene," "ulcer," "tumor," "accident," "fracture," "injury," "operation," "malpractice," "homicide," "suicide," are not sufficient. Correct age is especially important. Physician please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerosis
DUE TO
(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L. Kemp M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED July 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 25.49	Mt Arburn Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS
Elroy O. Wilson 1000 Brantly Ave.

VS 151

97

G76490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76490 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Paul A. Thiel

2. DATE OF DEATH: July 21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 323 N Robinson st

C. Length of stay in Baltimore 70 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 323 N Robinson St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto md 6-01.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	married	Aug 15-1858	90		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ship Captain

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Thiel - 119 Highland Ave ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis

DUE TO

(B) X

DUE TO Lobar Pneumonia 14 months ago

(C) Lobar pneumonia 4 months ago

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. X

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	48

22. *I hereby certify that I attended the deceased from* May 1, 1[illegible] *to* July 20-, 1949 *that I last saw the deceased alive on* July 21, 1949 *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Allen C. Beacham M. D.	3139 E. Baltimore	July 21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	July 23 49	Holy Redeemer	Balto

DATE RECEIVED BY LOCAL REGISTRAR: JUL 22 1949

REGISTRAR'S SIGNATURE: Washington Williams, M.D.

25. FUNERAL DIRECTOR: Joseph J. Hess & Son ADDRESS: 3001 Kentucky Ave

94a

VS 150

PLEASE WRITE LEGIBLY. Physician: please write the cause of death clearly and legibly. Be sure to give correct age if especially important.

G76491 Peake

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76491

1. NAME OF DECEASED (Type or Print): Charles E. Williams

2. DATE OF DEATH: July 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2903 Glenmore Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore — Yrs. Mos. Days:

D. STREET ADDRESS (If rural, give location): 2903 Glenmore Avenue 27-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
male	white	married	Feb. 5, 1883	66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer		Virginia	

13. FATHER'S NAME: James F. Williams

14. MOTHER'S MAIDEN NAME: Emma E.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mrs. Annie E. Williams	2903 Glenmore

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — Interval between onset and death: Instant

DUE TO

(B) Coronary Sclerosis — 2 Years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-5-, 1940 *to* 7-21-, 1949, *that I last saw the deceased alive on* 7-20-, 1949, *and that death occurred at* 12:15 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. W. Peake M. D.	4508 Harford Road	7-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-23-49	Lorraine Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Emily for Williams, M.D.	Leonard J. Ruck	5305 Harford Road.

VS 150

94a

BIRTH NO. 76493 Freeman

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 76492

1. NAME OF DECEASED (Type or Print): Joseph Nelson Woolford
2. DATE OF DEATH: July 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3209 Northern Parkway
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3209 Northern Parkway 27-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widowed	Jan. 26, 1871	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Worchester Co Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wm. Washington Woolford
14. MOTHER'S MAIDEN NAME: Laura Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. W.J.Woolford, ADDRESS: 3209 Northern Pkw

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction, acute — INTERVAL BETWEEN ONSET AND DEATH: immediate

DUE TO

(B) Arteriosclerotic Heart disease — 5 or more years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1946, *to* July 22, 1949, *that I last saw the deceased alive on* July 19, 1949, *and that death occurred at* 7.45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Maria Freedman M. D.	1737 E. North Ave	22 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-25-49	Moreland Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 22 1949 VS 150	Huntington Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

93D

G76493 Blienfeld
714 E. Preston
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47 0 1

Registered No. G76493

1. NAME OF DECEASED (Type or Print): Henry Joseph Hammel

2. DATE OF DEATH: July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 741 E. Preston Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 741 E. Preston Street 10-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Aug. 25, 1903	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Refrigerator Service
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph V. Hammel
14. MOTHER'S MAIDEN NAME: Anna Marie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Marie A. Hammel, ADDRESS: 741 E. Preston

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs.
DUE TO
(B) —
DUE TO
(C) —

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1949, *to* 20 July, 1949, *that I last saw the deceased alive on* 20 July 1949, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Samuel Isenfeld M. D.
23B. ADDRESS: 714 E. Preston St.
23C. DATE SIGNED: 21 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-23-49	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Ruck
ADDRESS: 5305 Harford Road.

VS 150

94a

Please write the cause of death clearly and legibly. Physician please write the correct age is especially important.

G76494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76494

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harmon, Clara A.

2. DATE OF DEATH: July 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22 Dundalk
D. STREET ADDRESS (If rural, give location): 1925 Rotherwood Road

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Jan. 3, 1896
9. AGE (In years last birthday): 53 52
If Under 1 Year: Months 6 Days 18
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Johnston
14. MOTHER'S MAIDEN NAME: Minnie Carney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Miss S. Schellberg ADDRESS: Church Home & Hospital

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Generalized Carcinomatosis	1 yr.
DUE TO	(B) Carcinoma of tail of pancreas	2 yrs.
DUE TO	(C) Diabetes Mellitus	18 yrs.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 19, 1949, to July 21, 1949, *that I last saw the deceased alive on* July 20, 1949, *and that death occurred at* 5:00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: James T. Means M.D.
23B. ADDRESS: Church Home and Hospital
23C. DATE SIGNED: July 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 24, 1949
24C. NAME OF CEMETERY OR CREMATORY: River View Cemetery
24D. LOCATION (City, town, or county) (State): Aliquippa, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Roland L. Fisher ADDRESS: 2112 Dundalk Ave.

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Physician please write the cause of death clearly and legibly. Correct age is especially important.

G76495

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

G76495

Registered No.

1. NAME OF DECEASED (Type or Print): Mary E. Knapik

2. DATE OF DEATH: 7/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 226 S. Eaton St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 226 S. Eaton St. 26-08

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12/13/96
9. AGE (In years last birthday): 52yrs.
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lawrence Semski
14. MOTHER'S MAIDEN NAME: Anna Swiston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-01-2627

17. INFORMANT: Frank Knapik
ADDRESS: 226 S. Eaton St.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertension - Coronic Vascular Disease
DUE TO
(B) Arterio - Sclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 2 1949 to July 21, 1949, that I last saw the deceased alive on July 21, 1949, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Arthur Henry Groth M. D.
23B. ADDRESS: 2577 Eaton Ave
23C. DATE SIGNED: 7/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/25/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George A. Weber
ADDRESS: 705 S. Ann St.

93D

G76496

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76496

Registered No.

1. NAME OF DECEASED (Type or Print): CLAUDE EVERHART LEBER

2. DATE OF DEATH: July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1712 Bolton St.

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1712 Bolton St. 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Jan. 5, 1875	74 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales Supt. (Rtd)	Tea & Spices	Baltimore, Md.	

13. FATHER'S NAME: Charles L. Leber

14. MOTHER'S MAIDEN NAME: Cora Everhart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Mrs. Margaret L. Leber — ADDRESS: 1712 Bolton St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Hemorrhage	3 years
	DUE TO	
ANTECEDENT CAUSES	(B) General Arteriosclerosis	5 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Diabetes Mellitus	5 years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 1, 1948, *to* July 21, 1949, *that I last saw the deceased alive on* July 21, 1949 *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hubert F. Pullman M. D.	6 E Biddle St	7/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/23/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

PLEASE WRITE PLAINLY, with ink. Make no erasures. Be sure to write the cause of death clearly and legibly. Physician please write the correct age is especially important.

VS 150

61

G76497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

154

Registered No. G76497

BIRTH NO.

1. NAME OF DECEASED (Type or Print): O. KENNETH QUIVEY

2. DATE OF DEATH: July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 301 Thornhill Rd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 301 Thornhill Rd. 7-7-14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Mar. 26, 1886	63 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Agent - Agricultural	Railroad	Rensselaer, Ind.	

13. FATHER'S NAME: Edward Quivey

14. MOTHER'S MAIDEN NAME: Allie McClure

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	World War #1		Mrs. Helen B. Quivey	301 Thornhill Rd

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Exactness and completeness are important. Physician please write the cause of death clearly and legibly. Correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adeno carcinoma of Rectosigmoid & Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 6 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Mar 12, 1949	Adenocarcinoma of Rectosigmoid & Metastases	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 26, 1949 *to* July 21, 1949, *that I last saw the deceased alive on* July 21, 1949, *and that death occurred at* 12 Noon *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward D. Cotter M. D.	11 E. Chase St.	July 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Removal	7/23/49	Rose Hill Cem.	Chicago, Ill.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Williams, M.D.	Wm. J. TICKNER & SONS	Balto., Md.

VS 150

467

G76498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76498

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Sadie E. Wilmer

2. DATE OF DEATH July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3722 Roland Avenue
c. Length of stay in Baltimore 55 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3722 Roland Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	White	Married	Feb. 7, 1880	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	---	Maryland	U S A

13. FATHER'S NAME: Jacob A. Buell

14. MOTHER'S MAIDEN NAME: Margaret J. Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
---	---

17. INFORMANT: Charles F. Wilmer ADDRESS: 3722 Roland Avenue

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral thrombosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B) Senile dementia
DUE TO
(C) Malnutrition

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1948 to July 20, 1949 that I last saw the deceased alive on July 20, 1949 and that death occurred at 6:25 P. m., from the causes and on the date stated above.

23A. SIGNATURE Dr Thos. H. Talbot M. D. | 23B. ADDRESS 4509 Liberty Heights Ave | 23C. DATE SIGNED 7-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 23, 1949	Woodlawn	Baltimore Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

48B

PLEASE WRITE PLAINLY, WITH UNFADING INK. In reporting the cause of death clearly and legibly. Please write the cause of death correctly. Physician please write plainly. Physician please write

G76499 — BALTIMORE CITY HEALTH DEPARTMENT — 400 — G76499

BIRTH NO. — **CERTIFICATE OF DEATH** — Registered No.

1. NAME OF DECEASED (Type or Print): Jesse Hicks — 2. DATE OF DEATH: 7-21-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Bells.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: 3 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bells. — 5-03
D. STREET ADDRESS (If rural, give location): 1622 N. Smallwood St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Cl.	Married	Feb. 17-1918	31		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur		Ledey Va	U.S.A.

13. FATHER'S NAME: Delaware Hicks

14. MOTHER'S MAIDEN NAME: Lucy Mae Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Bertha Hicks — ADDRESS: 1622 Smallwood St

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Enter the cause of death clearly and legibly. Physician: please write the correct age is especially important.

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Secondary Shock — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Ruptured Sept. c Ulcer

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-21 *, 19*49 *to* 7-21 *, 19*49 *that I last saw the deceased alive on* 7-21 *, 19*49 *and that death occurred at* 730 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr. Higgins per Dr. Buford M. D.	Provident Hospital	7-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 31-1949	Zion Cem.	Suffolk Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 22 1949	Huntington Williams, MD	Elroy A. Wilson	1000 Brantley Ave

VS 150

1170

G76500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

80

Registered No. G76500

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sharon Ann Marshall

2. DATE OF DEATH July 27 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland ✓

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL

c. Length of stay in Baltimore 22 DAYS ~~Yrs. Mos. Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY SOMERSET
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TIDALTON
D. STREET ADDRESS (If rural, give location) SMITH ISLAND

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	April 30, 1949		2 / 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Barbara Ann Smith

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME STANLEY H. MARSHALL

14. MOTHER'S MAIDEN NAME Maryland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT Barbara Ann Marshall ADDRESS Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Kidney Hypoplasia	8 hrs
DUE TO (B)	Hepatomegaly	2 1/2 mos.
DUE TO (C)	Septicemia	2 weeks
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	no	none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	none

22. *I hereby certify that I attended the deceased from* July 1, 1949 *to* July 22, 1949, *that I last saw the deceased alive on* July 21, 1949, *and that death occurred at* 4:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles T. Henderson M. D.	University Hospital	7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/22/49	TARLTON CEM	TARLTON, MD.

DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR HILLY & ZEILER INC ADDRESS 403 S. WOLFE

VS 150

52a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct as near as possible. Physician: please write the cause of death clearly and legibly. Age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

916.3 E

Registered No. G26501

G26501
BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES SCHEPLING N-948.7

2. DATE OF DEATH July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 511 S. Wolfe Street 2-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	3-16-1910	39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Don't Know

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles L. Schepling

14. MOTHER'S MAIDEN NAME Ida Mae Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Helen Schepling ADDRESS Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Second degree burns of 80% of body	
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Oil Refinery

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Esso Oil Refinery--Canton, Maryland

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 21, 1949 2:00 P m?

21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? Oil still explosion followed by fire 2/6

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE CHESTER J. LUBINSKI, M.D. PER: M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED 7-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7-25-49

24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1949

REGISTRAR'S SIGNATURE Hunter for Williams, M.D.

25. FUNERAL DIRECTOR LILLY & ZEILER ADDRESS 403 S. Wolfe Street

VS 151

181

76502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 Registered No. G76502

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Warren CRIST, Jr.

2. DATE OF DEATH: July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital

c. Length of stay in Baltimore: Yrs. 25 Mos. 4 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 3903 Wilkens Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3903 Wilkens Ave

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Jan. 11, 1875

9. AGE (In years last birthday): 74 yrs.
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: ?

11. BIRTHPLACE (State or foreign country): Balto. Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John. M. Crist

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-14-3940

17. INFORMANT: Mr. Warren E. Crist ADDRESS: 110 S. Cherrydale Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MASSIVE CEREBRAL HEMORRHAGE

DUE TO

(B) HYPERTENSIVE ARTERIOSCLEROTIC

DUE TO CARDIO-VASCULAR DISEASE

(C) BILATERAL PULMONARY EDEMA

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/21, 1949 *to* 7/21, 1949 *that I last saw the deceased alive on* 7/21, 1949 *and that death occurred at* 10:55 P. *from the causes and on the date stated above.*

23A. SIGNATURE: John H. Haas M. D.

23B. ADDRESS: 1 E. Lexington Balto.

23C. DATE SIGNED: 7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 7/25/49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 22 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS

ADDRESS: Balto., Md.

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

G76503 BALTIMORE CITY HEALTH DEPARTMENT 93 G76503
BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) MAX BECK, MAX — 2. DATE OF DEATH 9-22-49

3. PLACE OF DEATH: A. Baltimore City, Maryland UNIV. HOSP.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSPITAL
c. Length of stay in Baltimore — Yrs. 7 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY KENT
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) CHESTERTOWN
D. STREET ADDRESS (If rural, give location) 114 WATER ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	WIDOWED		64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER
10B. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CLARENCE MILLS
14. MOTHER'S MAIDEN NAME MARY ATKINSON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT HOSP RECORDS ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) GLIOBLASTOMA
DUE TO MULTIFORME PARIETAL REGION, RIGHT — INTERVAL BETWEEN ONSET AND DEATH: ABOUT 1 YEAR
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 7-19-49
19B. MAJOR FINDINGS OF OPERATION GLIOBLASTOMA MULTIFORME
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-19, 1949 *to* 7-22, 1949, *that I last saw the deceased alive on* 7-22, 1949, *and that death occurred at* 11:05 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE John W. Scott AND M. D.
23B. ADDRESS UNIV. HOSPITAL
23C. DATE SIGNED 9-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 7/24/49
24C. NAME OF CEMETERY OR CREMATORY ST. PAUL CEM.
24D. LOCATION (City, town, or county) (State) KENT CO. MD

DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR J. Willis Wells ADDRESS Chestertown, Md.

PLEASE WRITE PLAINLY, with unfading ink. Write the cause of death clearly and correct age is especially important. Physician: please write this only.

54a

G76504

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76504

Registered No.

1. NAME OF DECEASED (Type or Print): Robert L Sturdevant

2. DATE OF DEATH: July 22, 1949

3. PLACE OF DEATH: Baltimore City, Maryland 1121 4 E.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Ohio
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Toledo
D. STREET ADDRESS (If rural, give location): 3715 Westland Ave

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)
Male	White		11-21-48	7

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Ohio	

13. FATHER'S NAME: Richard Sturdevant

14. MOTHER'S MAIDEN NAME: Anne Jo Anastein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, with ink. Do not use abbreviations. Write the cause of death clearly and legibly. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Heart Disease

DUE TO

ANTECEDENT CAUSES

(B) 0

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) 0

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/22/49	Pulmonary Stenosis	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-1- 1949 *to* 7-22- 1949, *that I last saw the deceased alive on* 7-22 1949, *and that death occurred at* 12 40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature], M. D.	JOHNS HOPKINS HOSPITAL	7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	July 22/49	Toledo Ohio	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 23 1949	Huntington Williams, MD	Ulrich Funeral Home	2007 Aisquith

VS 150

157E

G76505
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76505

1. NAME OF DECEASED (Type or Print): Wm. J. Reading
2. DATE OF DEATH: July 21 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8 or
D. STREET ADDRESS (If rural, give location): 2302 E. Lafayette Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	11-9-97	51 52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	duPont Co	Md.	

13. FATHER'S NAME: Jacob Reading
14. MOTHER'S MAIDEN NAME: Mary Cunningman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		216-10-2316	JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Melanosarcoma
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(left eye)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 23, 1949 *to* July 21, 1949 *that I last saw the deceased alive on* July 21, 1949 *and that death occurred at* 4:40 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip D. Hagley M. D.	JOHNS HOPKINS HOSPITAL	7-21-49

24A. BURIAL, CREMATION OR REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/25/49	Mowbend Park	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 23 1949	Huntington Williams, M.D.	Wilson Co. Inc.	1217 Park St

VS 150

PLEASE WRITE PLAINLY, WITH INK OR INDELIBLE PENCIL. Write the cause of death clearly and correct age is especially important. Physician: please write this

153

G76506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76506

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): FOUNT LEGG

2. DATE OF DEATH: July 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? Yrs. 6 Mos. 4 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1516 E. Baltimore St. 6-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	1/21/99	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pumpman	Seafarer	Ga.	USA

13. FATHER'S NAME: S.A. Legg

14. MOTHER'S MAIDEN NAME: Annie Beck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW I	253-24-9972	Records- US Marine Hospital	Balto, Md.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY with pen or pencil, and state the cause of death clearly and correct age is especially important. Physician: please write the

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma involving pt. lower bronchus and

DUE TO (B) pyloric portion of stomach (Primary, on gross undetermined)

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

(A) Duration unk.

(B) Duration Unkn.

(C) Abscess, right lower lobe of lung

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* June 11, 1949, *to* July 22, 1949, *that I last saw the deceased alive on* July 22, 1949, *and that death occurred at* 11:56A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert P. Dudley M. D.	US Marine Hospital, Balto. Md.	7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/25/49	Natural	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 23 1949	Huntington Williams, M.D.	Wilson & Son	1218 Eutaw St

VS 150

46B

G76507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

177 G76507 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles B. Nicholson

2. DATE OF DEATH 7/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Reisterstown
D. STREET ADDRESS (If rural, give location) 109 Butler Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	~	5/26/1862	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Retired	W. Va	

13. FATHER'S NAME Michael

14. MOTHER'S MAIDEN NAME Georgiana Betson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Please write the cause of death clearly and legibly. Exact age is especially important. Physician: please write your name and address.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular

DUE TO

(B) Failure.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Transurethral Prostatectomy

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/21/49	Carcinoma Prostate	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/18 *1949 to* 7/22, *1949, that I last saw the deceased alive on* 7/22, *1949 and that death occurred at* 1:05 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank Guyer M. D.	St Agnes Hosp	7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/25/49	Loraine	Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 23 1949	Hunter for Williams, M.D.	Wilson & Son 1217 Eutaw St

VS 150

51B

G76508

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C.48-07882 **CERTIFICATE OF DEATH** E 88 L 0 Registered No. G76508

1. NAME OF DECEASED (Type or Print): PATRICIA WOODFORD N-96r 0

2. DATE OF DEATH: July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: 15 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2525 Francis Street 13-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored		Mar 28/48	1				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore Md.	

13. FATHER'S NAME: Eugene Woodford

14. MOTHER'S MAIDEN NAME: Dorothy Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Dorothy Jones ADDRESS: 2543 Francis St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia

DUE TO Kerosene Poisoning

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2208 Division Street 14/3

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: July 19, 1949 7:15 P m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Accidently drank kerosene

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: [signature] M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 7-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 23/49	Mt Calvary	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 23 1949

REGISTRAR'S SIGNATURE: [signature]

25. FUNERAL DIRECTOR: Va Brooks ADDRESS: 1463 N Caren St

179X

VS 151

PLEASE WRITE PLAINLY, WITH INK OR INDELIBLE PENCIL. Write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G76509

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

5810

Registered No. G76509

1. NAME OF DECEASED (Type or Print) Cross, Emory V.

2. DATE OF DEATH July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's

c. Length of stay in Baltimore 35 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 704 N. Bradford 7-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M.	W.	Single	3/25/1869	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ticket Collector	Redwing Movie	Balto. Co.	

13. FATHER'S NAME VALENTINE CROSS

14. MOTHER'S MAIDEN NAME SUSAN McCOUGH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	214-26-7912	MRS. KENNETH STANTON	7011 ALDEN RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Esophageal Varices — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Portal cirrhosis of the liver — DUE TO

(C) — DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* June 28, , 1949 *to* July 21, , 1949, *that I last saw the deceased alive on* July 21, 1949 *and that death occurred at* 6:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. L. Wollenweber, M. D.	1400 N. Caroline St.	July 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY	24D. LOCATION (City, town, or county) (State)
BURIAL	7/25/49	Gov. Powder [illegible] BAPTIST	MIDDLETOWN MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 23 1949	Huntington Williams, M.D.	J. T. STANSBURY	2700 EDMONDSON AV.

VS 150

PLEASE WRITE PLAINLY, with unfading ink. Complete the cause of death clearly and correctly. Exact age is especially important. Physicians: please write the

1248

GN. 16177

76510
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

Registered No. G76510

1. NAME OF DECEASED (Type or Print): John Tyson

2. DATE OF DEATH: 7- 17- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Since 1917 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1530 McElderry ST. 7-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Single	Dec. 7- 1888	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Ala.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Tyson	Matilda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Records. B.C.H 4940 Eastern Ave.

MEDICAL CERTIFICATION

PLEASE WRITE LEGIBLY. Omit terms of indefinite or uncertain meaning, such as "old age," "senility," "debility," "exhaustion," "cardiac failure," "respiratory failure," "uremia," "convulsions," etc., unless they are the only terms which can be certified. Do not abbreviate. Write the cause of death clearly and concisely. Physician: please write the exact age if especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident.
DUE TO
(B) Hypertensive Arterio Sclerotic Cardio Vascular Disease
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (m.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 3- 15- , 1928, *to* 7- 17- , 1949, *that I last saw the deceased alive on* 7- 17- 1949 *and that death occurred at* 6.40 PM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. S. Cowan M. D.	B.C.H. 4940 Eastern Ave	7- 23 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 22/49	Mt Calvary Cem	Balto County Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 23 1949	Huntington Williams, M.D.	Mrs Robt A. Ellis & Daughter	937 1127 N. Carlton St

VS 150

G76511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76511 Registered No.

1. NAME OF DECEASED (Type or Print): Dorothy Lawrenz (Lawrence)

2. DATE OF DEATH: July 21. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1218 Cleveland St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1218 Cleveland St. 21-07

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan 5. 1883
9. AGE (In years last birthday): 66 — If under 1 year: Months, Days; If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Switzerland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —

17. INFORMANT: William Lawrenz ADDRESS: 1218 Cleveland St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Myocarditis	4 yrs.
DUE TO (B)	Hypertension	6 yrs.
DUE TO (C)	Degenerative Arthritis	8 yrs.
	Secondary Anemia	2 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 5, 1948 *to* July 21, 1949 *that I last saw the deceased alive on* July 19, 1949 *and that death occurred at* 4.10 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas Yates M. D.
23B. ADDRESS: 517 Scott St.
23C. DATE SIGNED: July 22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 26. 1949
24C. NAME OF CEMETERY OR CREMATORY: Locustwood Memorial
24D. LOCATION (City, town, or county) (State): Elton N. J.

DATE REGISTERED: JUL 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Mrs. John H. Tenfelsen ADDRESS: 5311 Edmondson Ave

VS 150

93c

PLEASE WRITE PLAINLY, with ... ; please write the cause ... of death clearly and ... ; correct age is especially important. Physician: please write ...

G76512

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

581 Registered No. G76512

1. NAME OF DECEASED (Type or Print): FRANKLIN KENSYE

2. DATE OF DEATH: July 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 705 Brune Street 17-03

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 1892
9. AGE (In years last birthday): 57
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATCHMAN
10B. KIND OF BUSINESS OR INDUSTRY: F. A. Davis Co.
11. BIRTHPLACE (State or foreign country): NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS. GEORGIA PHILLIPS ADDRESS: 721 GEORGE ST.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, with ink. Do not use abbreviations. In stating the cause of death, please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis of liver
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 11

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY occur?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Emil L Boyer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 7-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 7-23-49.
24C. NAME OF CEMETERY OR CREMATORY: MT. AUBURN
24D. LOCATION (City, town, or county) (State): BALTIMORE. MD.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Wm. A. Jackson - 916 Penna. Ave

VS 151

124 B

G76513

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76513

Registered No.

1. NAME OF DECEASED (Type or Print) EUGENE THOMAS KERNAN

2. DATE OF DEATH 7/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4621 Keswick Road

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1508 Shadyside Road 9-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed	1876	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Peter Kernan

14. MOTHER'S MAIDEN NAME (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. ---

17. INFORMANT Mr. Eugene Kernan ADDRESS 1508 Shadyside Rd

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH INK. Fill in the cause of death clearly and correct age is especially important. Physician: please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO

(B) Generalized Arteriasclerosis — 10 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-18, 1949 *to* 8-19, 1949 *that I last saw the deceased alive on* 8-18, 1949 *and that death occurred at* 9 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE A. D. Lynn M.D. M. D.

23B. ADDRESS 4 E. Chase St

23C. DATE SIGNED 8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/22/49	Cathedral	City

DATE RECEIVED BY LOCAL REGISTRAR JUL 23 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR WIEDEFELD & SON ADDRESS GREENMOUNT AVE & 22ND

VS 150

94a

G76514

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76514

1. NAME OF DECEASED (Type or Print): DELOS M. PAGE

2. DATE OF DEATH: July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 809 Bonaparte Avenue
C. Length of stay in Baltimore: 9 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 809 Bonaparte Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	MARRIED		54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINEST
10B. KIND OF BUSINESS OR INDUSTRY: DIE-CRAFT CO.
11. BIRTHPLACE (State or foreign country): PA.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: GEO. PAGE.
14. MOTHER'S MAIDEN NAME: LIZETTA FINCHER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 176-16-3442
17. INFORMANT: MRS. MARG. M. PAGE — ADDRESS: 809 BONAPARTE AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary disease	
ANTECEDENT CAUSES	DUE TO (B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: J. Kalinski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 7-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 7-25-49
24C. NAME OF CEMETERY OR CREMATORY: WILDWOOD CEM. WILLIAMSPORT
24D. LOCATION (City, town, or county) (State): PA. —
ADDRESS
DATE RECEIVED BY LOCAL REGISTRAR: JUL 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, Mgr
25. FUNERAL DIRECTOR: WIEDEFELD & SON
940 GREENMOUNT AVE & 22ND

VS 151

PLEASE WRITE PLAINLY, with ... write the cause of death clearly and ... correct age is especially important. Physician: please ...

G76515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1 G76515

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): EDNA ESTELLE CRUMPTON

2. DATE OF DEATH: 7-22-49.

3. PLACE OF DEATH:
a. Baltimore City, Maryland 2815 Cold Spring Lane

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2815 Cold Spring Lane. 15 13.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Feb 14 - 1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
house-wife	—	Baltimore Md.	U.S.

13. FATHER'S NAME: George T. Mitchell

14. MOTHER'S MAIDEN NAME: Matilda ann Crook.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
	—	—

17. INFORMANT: Kathryn Tibby — ADDRESS: 2815 Cold Spring Lane

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Angina Pectoris	? years
	DUE TO	
ANTECEDENT CAUSES	(B) Coronary Thrombosis	9 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* October, 1939 *to* July 22-, 1949, *that I last saw the deceased alive on* 7-21-, 1949, *and that death occurred at* 9.05a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chester Ruland, M. D.	2532 Edmondson Ave	7-22-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 25 1949	London Park Cemetery	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 23 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Ellis S. White — ADDRESS: 2810 Cold Spring Lane

VS 150

94a

PLEASE WRITE PLAINLY. Fill in all blanks by typewriter or print in ink. Write the cause of death in terms of disease, injury, and means by which it occurred. Physician please write the correct age is especially important.

6516

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76516

Registered No.

1. NAME OF DECEASED (Type or Print): LENA H. DAVIES

2. DATE OF DEATH: July 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1812 Bolton St.
c. Length of stay in Baltimore: 45 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1812 Bolton St. 74-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widow	Nov. 3, 1859	89 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Glouster Co., Va.	

13. FATHER'S NAME: Patrick H. Fitzhugh

14. MOTHER'S MAIDEN NAME: Mary Christian

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Peregoy — ADDRESS: 1812 Bolton St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) arteriosclerotic cardiovascular disease	2 years +
	DUE TO (B)	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August, 1947, *to* 22 July, 1949, *that I last saw the deceased alive on* 22 July, 1947, *and that death occurred at* 3.30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Herbst Jr. M. D.	20 E. Preston St., Balt. 2, Md	22 July '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/25/49		Urbana, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 23 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

PLEASE WRITE PLAINLY. Please write the cause of death clearly and correct age is especially important. Physicians: please write the

93D

G76517

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76517

1. NAME OF DECEASED (Type or Print): BENJAMIN BOYER

2. DATE OF DEATH: July 18, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3000 Clifton Avenue

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1024 N. Gilmor Street 6-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Single		66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor		Anne Arundel Co., Md.	USA

13. FATHER'S NAME: Jessie Boyer

14. MOTHER'S MAIDEN NAME: Rachael Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: James Fields — ADDRESS: 1024 N. Gilmor St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: GEORGE G. MERRILL, M.D.
PER: [signature]
M.D.

23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 7-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 26	Mt. Auburn	West Port, Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 23 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Metropolitan Funeral Home Inc. ADDRESS: 927 W. Mount St

93D

VS 151

PLEASE WRITE THE CAUSE OF DEATH CLEARLY AND IN ENGLISH. Physician: please write the cause of death clearly and correct age is especially important.

76518

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

63

G76518

Registered No.

1. NAME OF DECEASED (Type or Print) Charles H. Lauf

2. DATE OF DEATH July 21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2023 Booth St.

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2023 Booth St. 20-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Divorced.	11/21/1883	65 66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Helper	Balto. Belting Co	Balto. Md.	U.S.A.

13. FATHER'S NAME Charles Lauf

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	216-07-2057	Harry R. Lauf	2023 Booth St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of lung	6 mths
	DUE TO	
ANTECEDENT CAUSES	(B) None	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C) None	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 1949 to July 21, 1949 *that I last saw the deceased alive on* July 20, 1949, *and that death occurred at* 1 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul Schofield M. D.	720 Cathedral	7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 23 '49	Cedar Hill	Maryland A H Co

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 23 1949	Hunter for Williams, M.D.	C. B. Nippert & Son	1300 Eutaw Pl.

47D

PLEASE WRITE IN PENCIL. Please write the cause of death in such terms as will be understood by the layman. Physician's please write clearly and use only such abbreviations as are commonly understood. Correct age is especially important.

G76519

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43

G76519

Registered No.

1. NAME OF DECEASED (Type or Print) Theresa M. Gately

2. DATE OF DEATH 7/21/49

3. PLACE OF DEATH: Baltimore City, Maryland — Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hosp

c. Length of stay in Baltimore: Yrs. Life, Mos., Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-19
D. STREET ADDRESS (If rural, give location) 5439 Jonquil Ave #15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	M.	10-3-1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY at home

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Tolan

14. MOTHER'S MAIDEN NAME First name unknown, Last name Coffey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT Patrick J. Gately, ADDRESS 5439 Jonquil Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident

DUE TO

(B) Hypertensive Cardio vascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/28, 1949, *to* 7/21, 1949, *that I last saw the deceased alive on* 7/21, 1949, *and that death occurred at* 11:5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Arlyn A. Wood M. D.

23B. ADDRESS West Balt. General Hosp

23C. DATE SIGNED 7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial

24B. DATE July, 25, 1949

24C. NAME OF CEMETERY OR CREMATORY Cathedral

24D. LOCATION (City, town, or county) (State) Baltimore, Md,

DATE RECEIVED BY LOCAL REGISTRAR JUL 13 1949

REGISTRAR'S SIGNATURE Timothy Williams, M.D.

25. FUNERAL DIRECTOR A. V. Lemmon

ADDRESS 4611 Park Hgts. Ave.

VS 150

93D

PLEASE WRITE PLAINLY. Please write the cause of death clearly and correct age is especially important. Physician please write the

G76520

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450.1 G76520

Registered No.

1. NAME OF DECEASED (Type or Print) MRS. ANNA Mc GREEVY

2. DATE OF DEATH 20 July '49.

3. PLACE OF DEATH: A. Baltimore City, Maryland YES

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS Hosp.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 345 Yale Ave. 20-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	6-14-1881	68 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Howard Co., Md.	

13. FATHER'S NAME: Thomas Foley

14. MOTHER'S MAIDEN NAME: Mary Whelan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		none	Mrs. Knighton	345 Yale Ave.

MEDICAL CERTIFICATION

Please write the cause of death clearly and completely. Physician please write correct age is especially important.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteria - Sclerosis, generalized c Gangrene of left foot — INTERVAL BETWEEN ONSET AND DEATH: 21 days.

DUE TO

(B) Acute Myocarditis — 1 day.

DUE TO

(C) Pyo - Nephrosis, Bilateral — 6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-11-49	Gangrene (dry) - left foot due Arteria Sclerosis	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 8, 1949, *to* July 20, 1949 *that I last saw the deceased alive on* July 20, 1949, *and that death occurred at* 7:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph R. Dolee, M. D.	Bon Secours Hosp.	20 July '49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	-7-23-49	Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 13 1949	Registrar for Williams, M.D.	C. Vernon Lemmon	4611 Pk. Hgts.

VS 150

133a

G76521

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76521

1. NAME OF DECEASED (Type or Print) Genevieve Anna Noppenberger

2. DATE OF DEATH July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Towson or (Rural)
D. STREET ADDRESS (If rural, give location) 406 E. Joppa Rd.

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 21 1901
9. AGE (In years last birthday) 48 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Baltimore Co.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Michael F. Hughes
14. MOTHER'S MAIDEN NAME Mary M. Handler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —

17. INFORMANT George L. Noppenberger ADDRESS 406 E. Joppa Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute lymphatic leukemia.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST,

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 8, 1949 *to* July 21, 1949 *that I last saw the deceased alive on* July 21, 1949 *and that death occurred at* 10:15 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE E. K. Kaan M. D.
23B. ADDRESS 1400 N. Caroline St
23C. DATE SIGNED July 21 19[illegible]

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 25-49
24C. NAME OF CEMETERY OR CREMATORY Mt. Maria Cem.
24D. LOCATION (City, town, or county) (State) York Rd.

DATE RECEIVED BY LOCAL REGISTRAR JUL 23 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Rippel Bros.
ADDRESS 7110 Belair Rd.

VS 150

74a

PLEASE WRITE PLAINLY with pen or pencil. Write the cause of death carefully and completely. Physician: please write the exact age is especially important.

G76522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 9 0 3 ° G76522

Registered No.

BIRTH NO.

N-870.1

1. NAME OF DECEASED (Type or Print) Dorothy Baer

2. DATE OF DEATH July 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 6028 old Harford

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Beech Hill Nursing Home

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 601 N. Robinson St.

7-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	July 13, 1881	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Fuchs

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Monroe L. Baer ADDRESS 5 N. Kenwood Ave.,

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture Neck Femur (Left)

DUE TO

(B) Hypostatic Pneumonia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
For Dr. E. J. Lubunsky
H. B. Merrill M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Slipped on floor

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Home 601 N. Robinson St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 7 - 3 - 49 m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Slipped on floor

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE Glenn Galley M. D.

23B. ADDRESS 5703 Harford Rd

23C. DATE SIGNED 7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 25, 1949

24C. NAME OF CEMETERY OR CREMATORY Baltimore

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 23 1949

REGISTRAR'S SIGNATURE Huntington-Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 2008 Orleans St.,

Vs 150

Please write plainly, preferably with typewriter. Physician, please write the cause of death clearly and legibly. Correct age is especially important.

186a

G76523

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

44 ✓ G76523 Registered No.

1. NAME OF DECEASED (Type or Print): ANNA DERR BENFER

2. DATE OF DEATH: JULY 22. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2117 ST. PAUL ST.

C. Length of stay in Baltimore: 34 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: BALTIMORE B. COUNTY: MARYLAND
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 2117 ST. PAUL ST. 12-04

5. SEX: female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: MAY 10, 1888 | 9. AGE (In years last birthday): 61 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): LEWISBURG PENNA.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: LEWIS KREMER DERR

14. MOTHER'S MAIDEN NAME: MOLLIE IZORA POULTNEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: MRS. GRAY WILLIAMS - ADDRESS: 2117 ST. PAUL ST.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Ch. Myocarditis	1945
DUE TO (B)	Ch. Interstitial Nephritis	1945
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Arteriosclerosis	1945
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 1, 1945 *to* July 22, 1949 *that I last saw the deceased alive on* July 21, 1949 *and that death occurred at* 6:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul Brown M. D. | 23B. ADDRESS: 1663 W. North Ave. | 23C. DATE SIGNED: 7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: July 25-1949 | 24C. NAME OF CEMETERY OR CREMATORY: Loudon Park | 24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 23 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Raymond C. Fink | ADDRESS: 3603 Belair Road

VS 150

1310

PLEASE WRITE PLAINLY. Please write the cause of death clearly and correct age is especially important. Physician please write the

G76524
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 G76524
Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES E. PETERS
2. DATE OF DEATH: 7/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1130 Inner Circle
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1130 Inner Circle 75-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	W	4/30/49 1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore	

13. FATHER'S NAME: John C. Peters
14. MOTHER'S MAIDEN NAME: Margaret Bayner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Family -	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Hypertensive Cardio-Vascular Renal
DUE TO
(C) Arteriosclerosis - Old age

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 20, 1949, to July 22, 1949, *that I last saw the deceased alive on* July 24, 1949, *and that death occurred at* 1 Am m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas Lakin M. D.	320 Patapsco Ave	7/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	7/25/49	Cedar Hill	Brooklyn

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 23 1949	Courtesy for Williams, M.D.	James L. McCauley	130 E. Fort Ave

VS 150

937

PLEASE WRITE CLEARLY — Fill in the calling for cause of death correctly and completely. Physician's signature is especially important. Please write the correct age.

G76525

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Register's No. G76525

1. NAME OF DECEASED (Type or Print) LOUIS STOLLAR

2. DATE OF DEATH 7-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 194 N. Wolfe St. 6-64

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	8/5/1895	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Inspector		Baltimore	

13. FATHER'S NAME Jacob Stollar

14. MOTHER'S MAIDEN NAME EMMA Vestivaldt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or No) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Family Home

MEDICAL CERTIFICATION

Please write clearly with pen and ink. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 9 hrs

DUE TO

(B) CORONARY OCCLUSION — 9 hrs

DUE TO

(C) CORONARY ARTERIOSCLEROSIS?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
—	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 7-20-19 49 *to* 7-20-19 49 *that I last saw the deceased alive on* 7-20-19 49 *and that death occurred at* 5:05 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Alan G. Pulley Jr. M. D.	SBGH	7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B.	7-15-49	Holy Redeemer	Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 23 1949	Certified from Baltimore, Md.	James L. McCauley 130 E. Fort Ave. 94a

VS 150

G76526

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

45-01

G76526

Registered No.

1. NAME OF DECEASED (Type or Print): JESSE E. DELL

2. DATE OF DEATH: 7/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

C. Length of stay in Baltimore: Yrs. [illegible] Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 823 Poplar Grove St.

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify): | 8. DATE OF BIRTH: June 20, 1864 | 9. AGE (In years last birthday): 85 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock. Self. Retired Farmer | 10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md. | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jesse E. Dell

14. MOTHER'S MAIDEN NAME: Susannah Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): — (If yes, give war or dates of service): — | 16. SOCIAL SECURITY NO.: —

17. INFORMANT: Son | ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolism

DUE TO

(B) Possible Carcinoma

DUE TO

(C) Cancer of Prostate.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/6 *to* 7/21 *, 19* 49 *that I last saw the deceased alive on* 7/21 *, 19* 49 *and that death occurred at* 4:45 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Walter Nichols M. D. | 23B. ADDRESS: University Hosp | 23C. DATE SIGNED: 7/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 7-24-49 | 24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Chapel | 24D. LOCATION (City, town, or county) (State): Randallstown, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 23 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: George A. Farley | ADDRESS: Fulton Ave - Fayette St.

Please write plainly with pen or pencil; please write the correct age is especially important. Physician:

VS 150

129

ES-130483

BIRTH NO. G76527

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76527

1. NAME OF DECEASED (Type or Print): Reva Gullion

2. DATE OF DEATH: 7-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
C. Length of stay in Baltimore: 1 Yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fallston
D. STREET ADDRESS (If rural, give location):

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 29, 1947
9. AGE (In years last birthday): 2 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Conley Gullion
14. MOTHER'S MAIDEN NAME: Flora Hawf
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Diarrhea
DUE TO
Heart Failure

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Mongalism
DUE TO
(C) Congenital Heart Disease

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-22, 1949, *to* 7-23, 1949, *that I last saw the deceased alive on* 7-23, 1949, *and that death occurred at* 9:15 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE: R. L. Rogers M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 7-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 24. 1949
24C. NAME OF CEMETERY OR CREMATORY: Jerusalem Christian
24D. LOCATION (City, town, or county) (State): Joppa. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: W. H. Archer
ADDRESS: Bel Air Md

VS 150

157E

PLEASE WRITE THE CAUSE OF DEATH CLEARLY AND ACCURATELY; please write the cause of death clearly and accurately; correct age is especially important. Physician: please write the cause of death clearly and accurately; correct age is especially important.

G76528 BALTIMORE CITY HEALTH DEPARTMENT G76528
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Mary Helen Lego
2. DATE OF DEATH July 22-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3314 Elm Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3314 Elm Ave 13-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widow	Nov 12-1883	65	8	10

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Also if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
house wife		Md	U.S.

13. FATHER'S NAME John O'Neill
14. MOTHER'S MAIDEN NAME Cummings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mrs Margaret Miller	3314 Elm Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Myocardial insufficiency	2 days
DUE TO (B)	Arterio Sclerosis	10 years.
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1949 *to* July 21, 1949, *that I last saw the deceased alive on* 7-21, 1949, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Arthur J Davis M. D. | 23B. ADDRESS 3000 W 33rd | 23C. DATE SIGNED 7-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 26-49	Mountain Christian	Joppa Harford Co Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 24 1949 | REGISTRAR'S SIGNATURE Hunter for Williams, M.D. | 25. FUNERAL DIRECTOR Frank H Derby & Co | ADDRESS 8/4 W 36th St

VS 150

93D

Please write in ink. Physician: please write the cause of death in terms of disease and not in terms of mode of dying, such as heart failure, asthenia, etc. Be sure that the exact age is especially important.

✓ G76529

G76529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 581 1

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Henry Louis Heathcote

2. DATE OF DEATH July 21 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Md. University Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days 2y

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 664 W. Fayette St 4-0 r

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	married	Aug 20, 1900	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labourer.	—	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Norman C. Heathcote	Minnie Kight.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	no	—	Mrs. Minnie Heathcote	905 W 34 St

MEDICAL CERTIFICATION

Please write the cause of death clearly and correct age is especially important. Physician: please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Bleeding from oesophageal varices	24 Hrs
DUE TO (B)	Hepatic cirrhosis	2 yrs.
DUE TO (C)	Chronic alcoholism	5 yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-20-30 1949 *to* 7-21, 1949 *that I last saw the deceased alive on* 7-21, 1949, *and that death occurred at* 5 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Adler M. D.	Univ. Hosp	7-22

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 25/49	St. Mary's, Hampden	Poland Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 24 1949	Huntington Williams M.D.	Einstein E Donovan	3818 Poland Ave

VS 150

124a

Dr. Krumrein G76530 ✓ 4 4 ✓ G76530

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Catherine A. Sauter

2. DATE OF DEATH July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3227 Shannon Drive

c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3227 Shannon Drive 26-03

5. SEX female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH July 31, 1869 | 9. AGE (In years last birthday) 79 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore co Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Migan

14. MOTHER'S MAIDEN NAME Catherine Kelley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS Mr. Wm. H. Sauter, 3227 Shannon Dr.

MEDICAL CERTIFICATION

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Uremia – Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH July 15/49

DUE TO

(B) Cardio – Vascular – renal Hypertension – —

DUE TO

(C) Arteriosclerosis — —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 15, 1949 *to* July 21, 1949 *that I last saw the deceased alive on* July 21, 1949 *and that death occurred at* 8 20 *m., from the causes and on the date stated above.*

23A. SIGNATURE Louis H. Krumrein, M. D. — 23B. ADDRESS 722 No. Kenwood Ave — 23C. DATE SIGNED July 22/49.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE 7-25-49 — 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer — 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

25. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, 5305 Harford Road.

SIGNATURE OF LOCAL REGISTRAR — REGISTRAR'S SIGNATURE Washington Williams, MD

VS 150

131a

Dr. Nowak G76531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 3 1

G76531 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William R. Hoover

2. DATE OF DEATH: July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 622 S. Milton Avenue
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 705 S. Milton Avenue 1-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widowed	Mar. 7, 1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired P.R.R.
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Mr. John Hoover, 705 S. Milton Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage — 5 days
DUE TO
(B) Arterio sclerosis & hypertension
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 16, 1949, *to* July 21, 1949, *that I last saw the deceased alive on* July 21, 1949 *and that death occurred at* 3:55 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sigmund R. Nowak M. D. | 23B. ADDRESS: 408 S. Patterson Park Ave. | 23C. DATE SIGNED: July 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 7-25-49 | 24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart | 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 24 1949 | REGISTRAR'S SIGNATURE: Lexington Williams, M.D. | 25. FUNERAL DIRECTOR — ADDRESS: Leonard J. Ruck, 5305 Harford Road.

VS 150

83a

Object age is especially important. Physician: please write clearly.

JL- 676532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 903.7 676532 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John P. Shipley

N - 820.1

2. DATE OF DEATH July 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 27 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 605 Benninghaus Rd. 7-48

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Wid.	Aug, 22, 1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Paul Shipley	Mary Klone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		B. C. H.	Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture of right Hip (united
Kyphoscoliosis, severe

CHIEF OR ASST. MEDICAL EXAMINER M. D.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
May 27, 1949	Insertion of Smith-Peterson Nail- Right Hip	YES Yes NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Fracture R. Hip	Infirmary Bldg. B. C.	H4940 Eastern Ave. 26/12

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
May 24, 1949 m.	WHILE AT WORK ☐ NOT WHILE AT WORK No	Fell during dizzy Spell

22. *I hereby certify that I attended the deceased from* 3-30-22, 19__, *to* July 22, 1949 *that I last saw the deceased alive on* July 22, 19 49 *and that death occurred at* 6.25PM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	4940 Eastern Ave.	July 23, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/25/49	Baltimore	north + Rose Sts

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
		Clarence F. Hoffman	1639 Broadway

To be approved by Medical Examiner.

VS 150

186a

Physician is especially important. Please write carefully and correct age is especially important.

G76533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G76533 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Frederick Helm

2. DATE OF DEATH July 22,1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 909 S.Clinton St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 909 S.Clinton St. 26 - 11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W	W	May 11,1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Coppersmith

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Helm

14. MOTHER'S MAIDEN NAME: Charlotte Pabst

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Charles Helm ADDRESS: 909 S.Clinton St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Chronic cardio vascular renal dis — 4 yrs 5

DUE TO

(C)

II ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 15, 1949 *to* July xx, 1949, *that I last saw the deceased alive on* July xx, 1949, *and that death occurred at* 2:03 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE Geo D. Lyster M. D. | 23B. ADDRESS 432 N Patterson Park Ave | 23C. DATE SIGNED 7/23 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 7/25/49 | 24C. NAME OF CEMETERY OR CREMATORY: Schwabtzs | 24D. LOCATION (City, town, or county) (State): O'Donnell St.

DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS: Clarence F. Hoffmann 1639 Broadway.

VS 150

1310

Important. Physician please write correct age is especial

G76534 ✓ G76534

BIRTH NO. G76534

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH E 91 (3 [illegible])

Registered No. N-1948-7

1. NAME OF DECEASED (Type or Print): WILLIAM Emmerich

2. DATE OF DEATH: July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3213 Dillan Street 26-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
Male	White	Divorced	Sept. 30, 1899	49	-	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chielf Operator	Standard Oil Co.	Baltimore	

13. FATHER'S NAME: William

14. MOTHER'S MAIDEN NAME: Katharine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Clara Emmerich 200 N. Conkling St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Second degree burns of 75% of body	
DUE TO		
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Oil Refinery	Esso Oil Refinery--Canton, Maryland

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 21, 1949 2 P m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Explosion and fire 26/6

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
[signature] M.D.		7-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/25/49	Oak Lawn	7225 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
		Clarence F. Hoffmann	1639 Broadway.

VS 151

161 ✓

DR. PEAKE

BIRTH NO. G76535

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 181 G76535

1. NAME OF DECEASED (Type or Print): Henrietta L. Crowley

2. DATE OF DEATH: July 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ardleigh Nursing Home

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution - residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3210 Berkshire Road 27-01

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	single	Oct. 2, 1879	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Auburn, New York	

13. FATHER'S NAME: J. Brooks Crowley

14. MOTHER'S MAIDEN NAME: Maria Louisa Bradt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Edwin Stein, 3210 Berkshire Rd. ADDRESS

MEDICAL CERTIFICATION

(Important. Physician: please write correct age is especially important.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Urinary Bladder — Interval between onset and death: 1 Year

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
March 1949	Carcinoma Urinary Bladder	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1940, 19__, *to* 7-22, 1949 *that I last saw the deceased alive on* 7-12, 1949 *and that death occurred at* 4 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. W. Peake M. D.	4508 Harford Road	7-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-25-49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 25 1949	Evelyn Williams, M.D.	Leonard J. Ruck, 5305 Harford Road.

523

Dr. White

BIRTH NO. 6776536

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6776536

1. NAME OF DECEASED (Type or Print): Catherine Margaret Evans

2. DATE OF DEATH: July 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 638 East 35th Street

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 638 East 35th Street -9-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
female	white	married	Aug. 20, 1905	43				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore Co Md.	

13. FATHER'S NAME: Andrew Huebler

14. MOTHER'S MAIDEN NAME: Mary Eppig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mr. Edward Evans, Jr. 638 E. 35th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage.— — INTERVAL BETWEEN ONSET AND DEATH: —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Cerebral Hemorrhage with Left Hemiplegia — 21 days.

DUE TO (C) Hypertensive Cardio Vascular disease — many years.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—		—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from Aug 47 to July 22 49, that I last saw the deceased alive on 22 July 49, and that death occurred at 5A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jane E. White M. D.	5214 Harford Rd.	25 July 49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-25-49.	Baltimore National	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
	Thurlington Williams M.D.	Leonard J. Ruck, 5305 Harford Road.

VS 150

JUL 24 1949

937

Correct age is especially important. Physicians: please

G76537

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

15 3

G76537

Registered No.

1. NAME OF DECEASED (Type or Print) Schroeder, Mr. Walter

2. DATE OF DEATH 7-23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home + Hospital

c. Length of stay in Baltimore 30 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-07
D. STREET ADDRESS (If rural, give location) 243 N. Monastery Ave

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct 5 1884
9. AGE (In years) last birthday) 64 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Schroeder Mr. Harry
14. MOTHER'S MAIDEN NAME Della, Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No —
16. SOCIAL SECURITY NO. 215-10-0816
17. INFORMANT Mrs. Mildred Willings ADDRESS Monastery Ave Balt. Md.

MEDICAL CERTIFICATION

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Gangrenous Thrombophlebitis — INTERVAL BETWEEN ONSET AND DEATH 2-3 days

DUE TO

(B) Infection of Operative Wound 3 weeks

DUE TO

(C) Carcinoma of Colon

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION June 2 1949
19B. MAJOR FINDINGS OF OPERATION Carcinoma of Colon
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1949 *to* July 23, 1949, *that I last saw the deceased alive on* July 23, 1949, *and that death occurred at* 1:09 A m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D. Ronald L. Heaton
23B. ADDRESS Church Home & Hospital
23C. DATE SIGNED July 23, 49

24A. BURIAL / CREMATION / REMOVAL (Specify) Burial
24B. DATE 7/25/49
24C. NAME OF CEMETERY OR CREMATORY Green Mount
24D. LOCATION (City, town, county) (State) York Co Pa

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wilson & Son
ADDRESS 1214 St Paul St

VS 150

46E

76538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76538

BIRTH NO. BC. 49-13549

1. NAME OF DECEASED (Type or Print): BABY PARKER

2. DATE OF DEATH: July 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2119 Levellyn St. 8-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
F	C		7-6-49			6 / 45

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore City	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: July 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State): JUL 2 2 1949

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Commissioner of Health

ADDRESS

VS 151

1612

76539

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76539

Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH GILLS

2. DATE OF DEATH: 7-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI Hosp

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1049 No. Broadway 7-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	Under 1 Year: Months / Days	Under 24 Hours: Hours / Min.
M	W	DIVORCED	4/24/99	49 50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: Sinai Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
- (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Esophageal VARICES (HEMORRHAGE) — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) PORTAL CIRRHOSIS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-14 *, 19*45 *to* 7-17 *, 19*45 *that I last saw the deceased alive on* 7-17 *, 19*49 *; and that death occurred at* 12 04 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leonard Kolb M. D.	Sinai Hosp	7-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	JUL 22 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949	Huntington Williams, M.D.	Commissioner of Health	

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124B

76540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76540

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry Ulrich Urlack

2. DATE OF DEATH: July 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp.

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 3402 Reisterstown Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white			66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry, *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
M.D.		7-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL JUL 2 2 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JUL 25 1949	Tuntington Williams, M.D.	Commissioner of Health

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Please write plainly; please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

76541

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

81.0 G76541

Registered No.

1. NAME OF DECEASED (Type or Print) RICHARD WOODS

2. DATE OF DEATH June 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) P.D. University Hospital
Found: Lot at 706 W. Fayette Street (rear)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 923 China Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored			67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Perforated Enlarged Varices

DUE TO

(C) Cirrhosis of Liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy — *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER [X] / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Emil Rupp M.D.		July 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL JUL 22 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 151

PLEASE WRITE PLAINLY. Use ink. Do not abbreviate. Be sure to write the cause of death clearly and correct age is especially important. Physician: please write the causes of death clearly and correct age is especially important.

724B

76542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76542

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRY H. YINGLING

2. DATE OF DEATH: 7-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SOUTH BALTIMORE GENERAL HOSPITAL

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 6815 Everall Ave. 7-05

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: May 28th, 1873
9. AGE (In years last birthday): 76 (If Under 1 Year: Months 1, Days 25; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Silas Yingling

14. MOTHER'S MAIDEN NAME: Meyers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-01-2873A

17. INFORMANT: Mrs. Harry H. Yingling ADDRESS: 6815 Everall Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CEREBRAL HEMORRHAGE
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-23-1949 *to* 7-23-1949, *that I last saw the deceased alive on* 7-23-1949, *and that death occurred at* 9¼ *m., from the causes and on the date stated above.*

23A. SIGNATURE: Harry D. Yingling M. D.
23B. ADDRESS: S. B. G. H.
23C. DATE SIGNED: 7-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 7/27/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949
REGISTRAR'S SIGNATURE: Hunter for Williams M.D.
25. FUNERAL DIRECTOR: Lasasha Funeral Home ADDRESS: 7401 Belair Rd.

VS 150

83a

G76543

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1143 G76543

1. NAME OF DECEASED (Type or Print): Emma M. Kelly

2. DATE OF DEATH: 23 July 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Hospital 27 N. Carey St
C. Length of stay in Baltimore: Yrs. 60+ Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1848 N Lebester St 8 05

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Sept 8th 1869
9. AGE (In years last birthday): 79 80
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Martinsburg W Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME: Isaac Silbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Kelley 1848 N Lebester St — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) arteriosclerotic & hypertensive cardio-vascular disease with marked degeneration

DUE TO and debility.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Neuro-dermatitis, severe.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 15 June, 1949, *to* 23 July, 1949, *that I last saw the deceased alive on* 23 July, 1949, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Emil W. Henning Jr M. D.
23B. ADDRESS: 4580 Edmondson Ave (29)
23C. DATE SIGNED: 23 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 27 1949
24C. NAME OF CEMETERY OR CREMATORY: Morelands
24D. LOCATION (City, town, or county) (State): Gayon Ave

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leo D. Leocke — ADDRESS: 1703 N Patterson Park Ave

VS 150

931

Correct age is especially important. Physician please write this

G76544

B.C. 48-21672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

571 0

Registered No. G76544

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SOUTH BALTIMORE GEN. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 MONTHS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE 22-01
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 So. HANOVER ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS NEWTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) OCT. 4, 1948

8. AGE: Years	Months	Days	If less than one day
	9	19	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leo Thomas Newton
13. Birthplace Oxford N.C.

MOTHER
14. Maiden Name Elizabeth Buckner
15. Birthplace Mannsville Penn

16 (a) Informant Leo T. Newton
(b) Address 530 S Hanover St

17 (a) Burial (b) Date thereof July 25 1949
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Harry A. Annacost
(b) Address 4204 Ridgewood Ave

JUL 25 1949
(Date rec'd by registrar)

Thurlington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1949, at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1949 to July 23 1949, and that I last saw h/m alive on July 23 1949.

Immediate cause of death	Duration
ACIDOSIS & DEHYDRATION	
Due to ACUTE ENTERITIS	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William B. Cooper Jr. M.d.
Address 213 Light St. Date signed 7/24/49
M. D.

119a

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G76545

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

G76545

Registered No.

1. NAME OF DECEASED (Type or Print): Della M. St. Clair

2. DATE OF DEATH: July 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 724 Melville Ave 9-03

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 26, 1893
9. AGE (In years last birthday): 56
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: David Clayton.
14. MOTHER'S MAIDEN NAME: Ella Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: George St. Clair ADDRESS: 724 Melville Ave.,

MEDICAL CERTIFICATION

Correct age is especially important. Physician - please write clearly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subdural Hemorrhage — 65 hr. 60 min
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
for Dr. Wm. G. Hartzell
William J. McClafferty M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: July 21, 1949
19B. MAJOR FINDINGS OF OPERATION: Subdural hematoma right
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): At home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 724 Melville, Balto.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 19 1949 6:30 A.M.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fell down stairs — no injury 9/3

22. I hereby certify that I attended the deceased from July 19, 1949, to July 22, 1949, that I last saw the deceased alive on July 21, 1949, and that death occurred at 12:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE: Wm Theiss Horton M. D.
23B. ADDRESS: Union Memorial Hosp
23C. DATE SIGNED: 7-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-25-49
24C. NAME OF CEMETERY OR CREMATORY: West Nottingham Presby. Church Cemetery
24D. LOCATION (City, town, or county) (State): Cecil Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: G. Howard Strong ADDRESS: 3207 W. North Ave.,

VS 150

83a

G76546

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

98.1 G76546

Registered No.

1. NAME OF DECEASED (Type or Print): Katie Wise

2. DATE OF DEATH: July 22,1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 131 S.Eaton St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 131 S.Eaton St.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location): 131 S.Eaton St. 76-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Mar.29,1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Balto. Md.	

13. FATHER'S NAME: Geo.Froelich

14. MOTHER'S MAIDEN NAME: Anna-?--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
---	----	-----

17. INFORMANT: John E.Wise ADDRESS: 131 S.Eaton St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Lymphosarcoma Retroperitoneal	2 yrs
DUE TO		
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C) Secondary Anemia	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-24-45, 19__, *to* 7-22-49, 19__, *that I last saw the deceased alive on* 7-22-49, 19__, *and that death occurred at* 7.55 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John Costantini, M. D.	234 Glenbeling St.	7-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 26/49	Oak Lawn Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949	Hunter for Williams, M.D.	Philip Herwig Sons	2024 Orleans St

VS 150

46H

Correct age is especially important. Physician: please write in full.

G76547

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76547

1. NAME OF DECEASED (Type or Print): Alexander Szandrowski

2. DATE OF DEATH: July 22-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1630 Ceddor St.

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1630 Ceddor St. 25-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W.	Married	March 15 1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shoemaker	SHOE	Austria	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Anna Jackson	1635 Ceddor St.

MEDICAL CERTIFICATION

(Physician: please write correct age if special or important.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

(B) Generalized arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia — 2 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from July 16 1949 to July 22 1949 that I last saw the deceased alive on July 22 1949, and that death occurred at 6 P. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sidney R. Gilbert M. D.	4700 Pennington Ave.	7/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 26-1949	Holy Cross	A A. Co'

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949	Huntington Williams, M.D.	Williams & Fralkowski	2003 Eastern Ave.

VS 150

83B

G76548

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76548 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles Lewis

2. DATE OF DEATH 7/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 613 Sharp Street 22-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	col.	S.	1/3/41	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child
10B. KIND OF BUSINESS OR INDUSTRY child

11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Sylvester Lewis ?
14. MOTHER'S MAIDEN NAME Lucy Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Lucy Lewis - 613 Sharp St ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) meningitis ?, Tuberculosis ?	?
DUE TO	(B) Pulmonary tuberculosis	?
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION none
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____ 19__ *to* ____ 19__, *that I last saw the deceased alive on* 7/23 1949 *and that death occurred at* 2:30A m., *from the causes and on the date stated above.*

23A. SIGNATURE John R. Hankins M. D.
23B. ADDRESS University Hospital, Balto, md.
23C. DATE SIGNED 7/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE 7/27/49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem
24D. LOCATION (City, town, or county) (State) A. A., Co., Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1949
REGISTRAR'S SIGNATURE Lucretia Williams, MD
25. FUNERAL DIRECTOR S. L. Brown & Son
ADDRESS 1048 W Montgomery St

13B

Correct age is especially important. Physician: please write the cause of death clearly.

G76549

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76549

1. NAME OF DECEASED (Type or Print) Lena Greenberg

2. DATE OF DEATH July 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2444 Callow Ave

c. Length of stay in Baltimore 17 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2444 Callow AVe 13-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Widow	1869	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Hungary	

13. FATHER'S NAME Samuel Saltzman

14. MOTHER'S MAIDEN NAME Etta ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Estelle Greenberg	2444 Callow Ave

MEDICAL CERTIFICATION

(Please answer all questions. Use extra sheet if necessary. Physician: please write clearly. Correct age is especially important. Physician: please sign.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Diabetes Mellitus

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT:

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1937 *to* July 25, 1949, *that I last saw the deceased alive on* 7-25 1949, *and that death occurred at* 4.15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. Edwin Levin M. D.	3700 Tilton Rd	7-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 26, 1949	Mount Hebron Cem	Long Island New York

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949	Huntington Williams, MD	Sol Levinson & Bros	1126 W North Ave

VS 150

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G76550

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97-6

G76550

Registered No.

1. NAME OF DECEASED (Type or Print): ANNA RIVERA

N- 967

2. DATE OF DEATH: July 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cockeysville, Md
D. STREET ADDRESS (If rural, give location): York Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	Unknown	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	General Household	Anasco, Puerto Rico	Puerto Rico

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Saturmina Echavarria

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
No	None	Dr. T. G. deQuevedo, Cockeysville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Strychnine poisoning.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arsenic ingestion

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Cockeysville, Md. (home)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-22-49 Approx. 11 P.M.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Ingestion of Strychnine Alkaloid & Arsenous Acid

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: July 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	July 26, 1949	San Juan, Puerto Rico	San Juan, Puerto Rico

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: John Burns' Sons, Towson, Maryland

VS 151

163E

Correct age is especially important. Physician: please write in full.

G76551

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1 ✓ G76551

Registered No.

1. NAME OF DECEASED (Type or Print): LENA KIRKWOOD FLEMING

2. DATE OF DEATH: 7-23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 726 NORTHERN PKWY.

c. Length of stay in Baltimore: 24 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 27-48
D. STREET ADDRESS (If rural, give location): 726 NORTHERN PKWY

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	WIDOWED	OCT. 10, 1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD.	U.S

13. FATHER'S NAME: JOSEPH KIRKWOOD

14. MOTHER'S MAIDEN NAME: ELIZABETH A. STRITEHOFF

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		—	J.W. FLEMING	SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Sudden.

DUE TO

(B) Cardio Renal Arteriosclerosis — 10 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 19 48 *to* July 23, 1949 *that I last saw the deceased alive on* July 20 19 49 *and that death occurred at* 4 30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles F. O'Donnell M. D.	2301 York Rd	7/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7-26-49	PROSPECT METHODIST	MT. AIRY MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949	Huntington Williams, M.D.	H.W. JENKINS & SONS CO.	4905 YORK RD.

VS 150

Direct age is especially important. Physician: please write plainly.

131a

G76552

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76552

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Michael Olszowski

2. DATE OF DEATH: 7/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 21 S. Conkey St
C. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 21 S. Conkey St 1-or.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 1870?
9. AGE (In years last birthday): 78
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None

17. INFORMANT: Josephine Rondeau
ADDRESS: 21 S. Conkey St

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: P. P. Lubinski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 7/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): B
24B. DATE: 7-26-49
24C. NAME OF CEMETERY: St. Stanislaus
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.

25. FUNERAL DIRECTOR: George A Weber
ADDRESS: 705 So Ann St

VS 151

47a

G76553 BALTIMORE CITY HEALTH DEPARTMENT 584 G76553

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) William L. Dawe

2. DATE OF DEATH 7-24-'49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore 7 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1310 E. 36th St. 9-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	W	Married	Oct. 21 1920	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Maintenance
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) N. Y.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME William Dawe
14. MOTHER'S MAIDEN NAME Marguerite Trapp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Dellinger & Son ADDRESS Woodstock, Va.

MEDICAL CERTIFICATION * (Exact age is especially important. Physician: please write plainly.)

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia with Nephrosis — INTERVAL BETWEEN ONSET AND DEATH about 10 days.

DUE TO

(B) Hepatitis following common duct obstruction (stones)

DUE TO

(C) Congenital Hemolytic Jaundice

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH; BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 7/11/49
19B. MAJOR FINDINGS OF OPERATION Choledocolithiasis; Hepato Splenomegaly; Jaundice
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-1- , 1949, to 7-20- , 1949, *that I last saw the deceased alive on* 7-24- , 1949, *and that death occurred at* 7 40/c *m., from the causes and on the date stated above.*

23A. SIGNATURE C. B. Thomas, Jr. M. D.
23B. ADDRESS Mercy Hospital
23C. DATE SIGNED 7-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal
24B. DATE 7/24/49
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State) Woodstock, Va.

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1949
REGISTRAR'S SIGNATURE Huntington Williams
25. FUNERAL DIRECTOR ADDRESS WM. J. TICKNER & SONS Balto.,

VS 150

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G76554

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76554

1. NAME OF DECEASED (Type or Print): Millie Kuehn

2. DATE OF DEATH: July 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 600 Chapel Gate Lane
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinecrest Nursing Home
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Linthicum Heights
D. STREET ADDRESS (If rural, give location):

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Feb. 20, 1880
9. AGE (In years last birthday): 69
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Rev. Chris. Kuehn

14. MOTHER'S MAIDEN NAME: Clara Seuel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Emma Kuehn ADDRESS: 205 E. Maple Rd., Lin. Hts.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) MANic -depressive psychosis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Generalized arteriosclerosis — ?

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1949, *to* July 23, 1949, *that I last saw the deceased alive on* July 23, 1949, *and that death occurred at* 2.35 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Melvin N. Borden M. D.
23B. ADDRESS: 2030 W. Fayette St.
23C. DATE SIGNED: 7/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 7/26/49
24C. NAME OF CEMETERY OR CREMATORY: St. Paul's
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Plac Baltimore, Md.

VS 150

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76555

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

31

G76555 Registered No.

1. NAME OF DECEASED (Type or Print) Charles L. Carroll

2. DATE OF DEATH 23 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore — 11
D. STREET ADDRESS (If rural, give location) 3952 Hickory Ave. 13-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	married	Sept 18, 1897	51 52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Millwright

10B. KIND OF BUSINESS OR INDUSTRY Western Electric

11. BIRTHPLACE (State or foreign country) Balto., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Charles J. Carroll

14. MOTHER'S MAIDEN NAME Magdalene Truestle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ✓ (If yes, give war or dates of service) ✓

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Alice C. Carroll ADDRESS 3952 Hickory A.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral hemorrhage

DUE TO

(B) Arteriosclerosis, cerebral

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION ~~June~~ 6 April 1949

19B. MAJOR FINDINGS OF OPERATION Intracerebral clot

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 July, 1949 *to* 23 July, 1949 *that I last saw the deceased alive on* 23 July, 1949, *and that death occurred at* 9:20 p *m., from the causes and on the date stated above.*

23A. SIGNATURE Jose A Alvarez-de Choudens M. D.

23B. ADDRESS University Hospital

23C. DATE SIGNED 23 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 27, 1949

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John O. Mitchell Sons

ADDRESS 1900 Eutaw Place

VS 150

83a

Please write in ink. Physician: please write plainly. Be sure that correct age is especially important.

GM. 130270

76556
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47

G76556
Registered No.

1. NAME OF DECEASED (Type or Print): Laura Ware

2. DATE OF DEATH: 7- 20- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 30 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1825 Etting St. 14-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Married	Sept. 18- 1903	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Getting
14. MOTHER'S MAIDEN NAME: Corean Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: B.C.H. Records 4940 Eastern Ave. (ADDRESS)

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Hypertensive Cardiovascular renal Disease

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7- 13- 1949 *, to* 7- 20- , 1949 *, that I last saw the deceased alive on* 7- 20- 1949 *, and that death occurred at* 1.25 AM *, from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave
23C. DATE SIGNED: 7- 21- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 25, 1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave. 1310

VS 150

Correct age is especially important. Physician, please write plainly.

6557 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

470.1 G76557 Registered No.

1. NAME OF DECEASED (Type or Print) Marguerite J. McCoo

2. DATE OF DEATH 7/24-44

3. PLACE OF DEATH: A. Baltimore City, Maryland 2324 Division

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3329 Division St.

C. Length of stay in Baltimore 30- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 2324 Division

14-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow	Oct. 16, 1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Gloucester, Va	U. S. A.

13. FATHER'S NAME: John Bright

14. MOTHER'S MAIDEN NAME: Fannie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No.

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Beatrice Bright ADDRESS 3329 Divis St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 7/1 '44 *to* 7/24 '44 *that I last saw the deceased alive on* 7/24 '44 *and that death occurred at* 7:32 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Ben Rhulta M. D. | 23B. ADDRESS 2134 Druid Hill Ave | 23C. DATE SIGNED 7/24/44

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY Family lot | 24D. LOCATION (City, town, or county) (State) Gloucester, Va

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1944 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Holland Funeral Home | ADDRESS 1631 Druid Hill Ave.

VS 150

94a

correct age is especially important. Physicians: please write clearly.

A 71561

G76558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

193 Registered No. G76558

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sandra Dale Litten

2. DATE OF DEATH JUL 25 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Fla.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Miami
D. STREET ADDRESS (If rural, give location) 3422 N.W. 14th Ter.

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S.
8. DATE OF BIRTH 1-14-48
9. AGE (In years last birthday) If Under 1 Year: Months 18, Days; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Fla.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Robert Litten
14. MOTHER'S MAIDEN NAME Gwendolyn Powell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Increased intracranial pressure — INTERVAL BETWEEN ONSET AND DEATH: 6 WK

DUE TO

(B) Brain tumor — over

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

20. AUTOPSY? YES ☐ NO ☐

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-18-, 1949 *to* 7-25-, 1949, *that I last saw the deceased alive on* 7-25-, 1949, *and that death occurred at* 12 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE Lowe Rhoads M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED JUL 25 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal
24B. DATE July 25-49
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State) Miami Florida
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR Bernard J. Tickner & Sons Belto Indy

VS 150

54a

Correct age is especially important. Physician: please write clearly.

G76559

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76559

1. NAME OF DECEASED (Type or Print): WILLIAM S. WRIGHT

2. DATE OF DEATH: July 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. 5/12 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 713 N. Eden Street 10-07

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: May 31 1909
9. AGE (In years last birthday): 40
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Laborer

11. BIRTHPLACE (State or foreign country): Balto Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Anthony Wright

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 213-03-2906

17. INFORMANT: Nannie Brown ADDRESS 172 Greenmount

MEDICAL CERTIFICATION

(Physician: please write distinctly and correct age is especially important. Physicians please fill in items 18 to 24 inclusive.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Degeneration
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 19 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE July 25-1949
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery
24D. LOCATION (City, town, or county) (State) A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Robert E. Williams ADDRESS 1517 Mc Elderry St

VS 151

937

G76560

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76560

1. NAME OF DECEASED (Type or Print) ROSA LEE LOWE

2. DATE OF DEATH July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 758 Redwood Street 4-or

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH
9. AGE (In years last birthday): 36 — If under 1 Year: Months / Days — If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Tillery, North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Austin
14. MOTHER'S MAIDEN NAME: Katie Willoby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Lelia Williams — ADDRESS: 758 Redwood St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Congestive Heart Failure
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *and from my own knowledge find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Paul L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED July 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE July 27, '49
24C. NAME OF CEMETERY OR CREMATORY: Mount Calvary
24D. LOCATION (City, town, or county) (State): Cedar Hill, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949
REGISTRAR'S SIGNATURE: Christine Van Williams, M.D.
25. FUNERAL DIRECTOR: CHARLES R. LAW — ADDRESS: 802 Madison Avenue

VS 151

93E

Correct age is especially important. Physicians please write the cause of death in plain English.

G76561

BIRTH NO. NANCY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 3 1

G76561

Registered No.

1. NAME OF DECEASED (Type or Print) Nancy DeLotch

2. DATE OF DEATH 7/22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland University Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Redwood & Greene Sts. Baltimore, Md.

c. Length of stay in Baltimore Yrs. 30yrs Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 724 N. Carey St. 1607

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	C	Married	6/8/1897	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Buford, NC.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Henry

14. MOTHER'S MAIDEN NAME Nora Henry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.

16. SOCIAL SECURITY NO.

17. INFORMANT Mary C. DeLotch ADDRESS 724 N. Carey St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Metabolic acidosis - etiology not established. — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Possible ponto-medullary lesion

DUE TO

(C) Hemorrhage

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/22 11AM, 1949, to 7/22 2AM, 1949, *that I last saw the deceased alive on* 7/22, 1949, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Fred R. McCrumb M.D.

23B. ADDRESS Univ. Hospital

23C. DATE SIGNED 7/23

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/26/49

24C. NAME OF CEMETERY OR CREMATORY Mount Calvary

24D. LOCATION (City, Town, or County) Cedar Hill, Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR H. Halstead ADDRESS 918 Druid Hill Ave.

VS 150

correct age is especially important. Physicians please write plainly.

83a

G76562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76562

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice Shea

2. DATE OF DEATH: July 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City Mf.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2305 Homewood Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 2305 Homewood Ave. 9-08

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: II/24/I883
9. AGE (In years last birthday): 65
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Harford Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: J. W. Holland
14. MOTHER'S MAIDEN NAME: Anna M. Pyle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: James A. Shea
ADDRESS: 2305 Homewood Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yr.

DUE TO

(B) Coronary Disease — 3 yr.

DUE TO

(C) Arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Nephritis — 2 years

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/4 19[illegible] *to* 7/23 19[illegible], *that I last saw the deceased alive on* [illegible] 19[illegible], *and that death occurred at* 7[illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE: Eugene L. Blum M. D.
23B. ADDRESS: 1115 N. Calvert St
23C. DATE SIGNED: 7/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/26/1949
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Flynn & Fleming, I426 Light St.
ADDRESS

VS 150

Correct age is especially important. Typewrite or print plainly in ink.

131a

G76563

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76563

1. NAME OF DECEASED (Type or Print) ESTELLE HARRIS

2. DATE OF DEATH July 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1372 Woodyear Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	colored		July ? 1885	XX64	—	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Balto. Md.	U. S. A.

13. FATHER'S NAME
Frank Harris

14. MOTHER'S MAIDEN NAME
Anna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		?

17. INFORMANT Alexander Anderson — ADDRESS 1372 Woodyear St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Ruptured aneurysm of circle of Willis.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		July 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 25, 1949	Laurel Cemetery	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 25 1949	Washington Williams, M.D.	Geo. G. Kelson 1303 Pressstmen St.

correct age is especially important. Physicians, please write clearly.

96

G76564 ✓ G76564

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mary C. Hancock

2. DATE OF DEATH: 7/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2261 W. Baltimore St
c. Length of stay in Baltimore: 4 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-04
D. STREET ADDRESS (If rural, give location): 2261 W. Baltimore St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 2/11/1884
9. AGE (In years last birthday): 65 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Charles Co. Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Alphonsus Murphy
14. MOTHER'S MAIDEN NAME: Mary Bridget

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mr Addison Hancock ADDRESS: 2261 W Baltimore St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 Yr
DUE TO
(B) Arteriosclerotic Cardiovascular Dis. 2 yrs
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb, 19 49 *to* 7/23, 19 49, *that I last saw the deceased alive on* 7/21, 19 49, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1946 W Balto St
23C. DATE SIGNED: 7/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/26/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: 937 Hollins St.

VS 150

Correct age is especially important. Physicians please write

JL- 91922 G76565

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76565

1. NAME OF DECEASED (Type or Print) Katherine Aleknovich

2. DATE OF DEATH July 23, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 50 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 641 W. Lombard St.

5. SEX F

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Wid.

8. DATE OF BIRTH Feb. 2, 1872

9. AGE (In years last birthday) 77 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Lithuania, Europe

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thadinis Lubinas

14. MOTHER'S MAIDEN NAME Veronica

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS B. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Arteriosclerotic Heart Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-2-45, 19__, *to* July 23, 1949, *that I last saw the deceased alive on* July 23, 1949, *and that death occurred at* 9.25 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE C. A. Rogers M. D.

23B. ADDRESS 4940 Eastern Ave.

23C. DATE SIGNED July 23, 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/26/49

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer

24D. LOCATION (City, town, or county) (State) Belair Road

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Charles W. Faehnrich ADDRESS 703 McHenry St

VS 150

61

Correct age is especially important. Physician - please write

G76566 X ✓ 154 G76566

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Raymond Smith

2. DATE OF DEATH July 24 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Balto General Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE W. Va. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Keyser
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	May 31, 1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) W. Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Adam P. Smith

14. MOTHER'S MAIDEN NAME Harra V. Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) GENERALIZED CARCINOMATOSIS

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 27, 1949, *to* July 24, 1949, *that I last saw the deceased alive on* July 24, 1949, *and that death occurred at* 6:20 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE William B. Cooper Jr. M.D.

23B. ADDRESS 1211 Light St

23C. DATE SIGNED 7/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal

24B. DATE 7/27/49

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State) Kingwood, W. Va

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John G. Connelly

ADDRESS Elkins, W. Va

VS 150

467

G76567

2431 Md ave

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

99-8

G76567

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) ARUTHUR DAY

2. DATE OF DEATH July 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1913 Eutaw Place

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wilight Rest Nursing Home

C. Length of stay in Baltimore 5 Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE
COUNTY 122 Market Place
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 4-01
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Widower	July 28 1882	67	1 20	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner	Coal Mine		

13. FATHER'S NAME
JAMES DAY

14. MOTHER'S MAIDEN NAME
ELIZABETH MARKS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Nursing Home Records 1913 Eutaw Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis, primary site unknown — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

(B) Silicosis — 1 yr.

DUE TO

(C) Sclerosis — sev. yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1949, *to* July 23, 1949, *that I last saw the deceased alive on* July 21 1949, *and that death occurred at* 10:40A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Elbert H. Cole M. D.	2431 Maryland Ave.	7/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 27/49	Allegany Co	Frostburg Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949	Huntington Williams, M.D.	David R. Trostle	2855 W. Fayette St

VS 150

55E

G76568

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76568 Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES FEDERLEICHT

2. DATE OF DEATH: 7/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Sinai Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

c. Length of stay in Baltimore: 50. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 17 13-01
D. STREET ADDRESS (If rural, give location): ALHAMBRA APTS, 211 Lake Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	single	12/25/99	69	7			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10B. KIND OF BUSINESS OR INDUSTRY: Dept Store

11. BIRTHPLACE (State or foreign country): Cincinnati Ind

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jacob Federleicht

14. MOTHER'S MAIDEN NAME: Belle Coblens - Belle Coblens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Edward Alhambra Apt ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal insufficiency

DUE TO

(B) Pyelonephritis

DUE TO

(C) ? infection following ureterostomy (BPE)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CVA, coronary sclerosis ASHD, pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1949, to 24 July, 1949 *that I last saw the deceased alive on* 23 July, 1949. *and that death occurred at* 10'5 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: William Finkelstein M. D.

23B. ADDRESS: Sinai Hospital

23C. DATE SIGNED: 7/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 26 49

24C. NAME OF CEMETERY OR CREMATORY: Clover Hill

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Harry Goodheim & Son 1402 Eastern Ave

VS 150

correct age is especially important. Physicians please write

93)

G76569 MH. 128888

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76569

1. NAME OF DECEASED (Type or Print) Henry Charmer

2. DATE OF DEATH July 23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 5 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) 720 W. Lexington St. 4-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Married	March 15, ?	50 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		S.C.	

13. FATHER'S NAME Richard Charmer.

14. MOTHER'S MAIDEN NAME Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Records Balto City Hospitals ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Far Advanced Pulmonary Tuberculosis.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-10, 1949, *to* 7-23, 1949, *that I last saw the deceased alive on* 7-23, 1949, *and that death occurred at* 3.30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE R. L. Rozen M. D. | 23B. ADDRESS | 23C. DATE SIGNED July 24, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-27-49	Mt. Auburn	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Wm. A. Jackson, ADDRESS 916 Penna. Ave.

correct age is especially important. Physicians: please write the

VS 150

13B

G76570
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76570

1. NAME OF DECEASED (Type or Print) **Ina S. Showacre**

2. DATE OF DEATH **July 22,1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **523 Normandy Ave.**
C. Length of stay in Baltimore: **Life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **523 Normandy Ave.** 20-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	**White**	**Single**	**July 31,1872**	**76**		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None**
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) **Baltimore, Md.**
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME **Michael S. Showacre**
14. MOTHER'S MAIDEN NAME **Annie R. Little**
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT **(sister)** ADDRESS **Miss Anna Mae Showacre,523 Normandy Ave**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) **Cardiac Failure**
DUE TO
(B) **Generalized arteriosclerosis** — **10 yrs.**
DUE TO **Paralysis agitans**
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/20/1949, 19__, *to* 7/22/49, 19__, *that I last saw the deceased alive on* 7/22/49, 19__, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS **3030 Edmondson Avenue.**
23C. DATE SIGNED **July 25, 1949**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial**
24B. DATE **July 26/49**
24C. NAME OF CEMETERY OR CREMATORY **Green Mount, Greenmount**
24D. LOCATION (City, town, or county) (State) **Ave.& Oliver St.Balto.MD**

DATE RECEIVED BY LOCAL REGISTRAR **JUL 25 1949**
REGISTRAR'S SIGNATURE [signature]
25. FUNERAL DIRECTOR **Harry A. Wintzfe**
ADDRESS **4101 Edmondson Ave.**

VS 150

87c

G76571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76571

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jacob Ebert

2. DATE OF DEATH July 24 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland 9 S. Woodington Rd
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 9. S. Woodington Rd
c. Length of stay in Baltimore 5 & yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived if in institution; residence before admission)
A. STATE 9 S Woodington Rd.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balt Md 28-04
D. STREET ADDRESS (If rural, give location) 9 S Woodington Rd.

5. SEX male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH Nov 24, 1866 | 9. AGE (In years last birthday) 82 | If under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ohio. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Ebert | 14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) None | 16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs Catherine Ebert | ADDRESS 9 S. Woodington Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Coronary Occlusion | INTERVAL BETWEEN ONSET AND DEATH 12 hours
DUE TO
(B) Generalized Arteriosclerosis ?
DUE TO
(C)

ANTECEDENT CAUSES.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION None | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 11, 1949 *to* July 24, 1949 *that I last saw the deceased alive on* July 24, 1949 *and that death occurred at* 2A m., *from the causes and on the date stated above.*

23A. SIGNATURE Earl Pass M. D. | 23B. ADDRESS 4001 Wilkens Ave | 23C. DATE SIGNED 7-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE July 27/49 | 24C. NAME OF CEMETERY OR CREMATORY London Park | 24D. LOCATION (City, town, or county) (State) Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1949 | REGISTRAR'S SIGNATURE Huntington Williams, MD | 25. FUNERAL DIRECTOR Harry H Wilkes | ADDRESS 401 Edmondson

VS 150

94a

RTIFICATE CORRECTED 8-1-49

G76572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59° G76572

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) James Kaufman (James. B. Kauffman) 2. DATE OF DEATH 4:09 P.M. July 23 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Doctors Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore 53 yrs (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 704 Charing Cross Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Sept. 6, 1891	58 57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. 10B. KIND OF BUSINESS OR INDUSTRY Bath City Water Dept

11. BIRTHPLACE (State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Winfield Kauffman 14. MOTHER'S MAIDEN NAME Amanda Carpenter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes - World I 16. SOCIAL SECURITY NO. None 17. INFORMANT Catherine M. Kauffman, wife ADDRESS 704 Charing Cross Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Cystic Lungs

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 7, 1949 *to* July 22, 1949, *that I last saw the deceased alive on* July 22 1949 *and that death occurred at* 1203 *m., from the causes and on the date stated above.*

23A. SIGNATURE Louis Kaufman M. D. 23B. ADDRESS 2730 N Charles St 23C. DATE SIGNED 7/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 7/26/49 24C. NAME OF CEMETERY OR CREMATORY London Pk. 24D. LOCATION (City, town, or county) (State) 3801 Frederick Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1949 REGISTRAR'S SIGNATURE Huntington Williams, M.D. 25. FUNERAL DIRECTOR Harry H. Nitzke ADDRESS 4101 Edmondson Ave.

VS 150

114E

CERTIFICATE CORRECTED 8-5/49

G76573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

434

Registered No. G76573

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SAMUEL Toulson CANN

2. DATE OF DEATH: July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 11 S. Fremont Street 4-07

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 7/12/1910
AGE (In years last birthday): 38
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Sandy Bottom Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel CANN
14. MOTHER'S MAIDEN NAME: ANNIE' Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.:

17. INFORMANT: Lucille Fisher
ADDRESS: 1006 Argyle Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute congestive cardiac failure

DUE TO

(B) Acute dilatation of the heart

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-26-49
24C. NAME OF CEMETERY OR CREMATORY: Sandy Bottom
24D. LOCATION (City, town, or county) (State): Sandy Bottom Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
FUNERAL DIRECTOR: Wm Wake R Williams
ADDRESS: 922 N. Schroeder St

VS 191

Correct age is especially important. Physician: please write plainly.

93E

D.G.D.
Med Exam Case
B.C.F. 9774

BIRTH NO. 67657

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76574

1. NAME OF DECEASED (Type or Print): James Johnson

2. DATE OF DEATH: JUL 22 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1626 E. Biddle St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored		3-15-	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Alfred Johnson	Catherine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

Correct age is especially important. Physicians please write plainly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Circulatory Collapse — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) Dysentery — ?
DUE TO
(C) Hirschsprung's Disease — life

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
John A. Davis
per H. J. McCafferty M.D.
MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* 7-22-, 1949 *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 4 05 p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harrison Clark Spencer M.D.	JOHNS HOPKINS HOSPITAL	7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 26-49	Mt Calvary Cem	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949 VS Y50	Huntington Williams M.D.	Elroy D. Wilson	1000 Brontleyville

To be Approved by Medical Examiner 27c

0765575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 0765575

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN L. SIMPSON

2. DATE OF DEATH: July 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: 1 DAY (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Georgia
B. COUNTY:
C. CITY OR TOWN (same) (If outside corporate limits, write RURAL and give township): Cordele, Georgia
D. STREET ADDRESS (If rural, give location): 311 Fourth Ave. N.W.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Aug. 3, 1912	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Day Co. Ga.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dave Lawson

14. MOTHER'S MAIDEN NAME: Lula Simpson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 253-10-9080

17. INFORMANT: Ethel Simpson ADDRESS: 311 Fourth Ave., N.W.

MEDICAL CERTIFICATION

(Please write correct age is especially important. Physicians: please write plainly.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute edema of lungs.
DUE TO
(B) Syphilitic aortitis.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Contusion of spinal cord.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Va.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 19, 1949 ? m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Auto. Accident

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ] homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: July 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 27, 1949

24C. NAME OF CEMETERY OR CREMATORY: Cordele Cem.

24D. LOCATION (City, town, or county) (State): Cordele, Ga.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Elroy O. Wilson 1000 Brantley Ave.

30D

G765576

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 re 1

Registered No. G765576

1. NAME OF DECEASED (Type or Print)	THOMAS EDWIN NOONAN	2. DATE OF DEATH	July 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1805 Park Ave.

c. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1805 Park Ave. 13-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	July 12, 1880	69 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Realty	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John T. Noonan	Ellen L. Avery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		212-09-1156	Mrs. Lula E. Noonan	1805 Park Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

(B) Hypertension Cardiovascular Renal — 6 months

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1949 *to* July 20, 1949 *that I last saw the deceased alive on* July 20, 1949, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Glassman M. D.	2687 Mosher Ave.	July 25 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Burial	7/27/49	Mt. Olivet Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949	Timothy Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

Correct age is especially important. Physician: please

931

Shepley ✓ X

G765577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 50.0

G765577

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Cornelius Patrick SHEPLEY

2. DATE OF DEATH 7/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gold Spring Nursing Home 2103 Gold Spring Lane

C. Length of stay in Baltimore 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Garrison

D. STREET ADDRESS (If rural, give location) St. Thomas Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	about 75 yrs old			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Sexton of Church	Baltimore Co. Md	

13. FATHER'S NAME Patrick SHEPLEY

14. MOTHER'S MAIDEN NAME Bridget BRENEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Anna Adams.	Edgewood Nursing Home, Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Arteriosclerosis — Interval between onset and death: 10 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 15, 1946, *to* July 23, 1949, *that I last saw the deceased alive on* 7/22, 1949, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas A. Sherman M. D.	3803 Edmondson Ave	7/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/26/49	St. Charles	Pikesville, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949	Huntington for Williams, MD	Frank H. Mowell	97 Pikesville, Md

VS 150

G76578

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

177 Registered No. G76578

1. NAME OF DECEASED (Type or Print): THOMAS JEFFERSON STEINHISE

2. DATE OF DEATH: July 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital
Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1306 S. Charles St. 23 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	9/29/78	70	9	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None -Retired	U.S. Coast Guard	Ohio	USA

13. FATHER'S NAME: Henry Steinhise

14. MOTHER'S MAIDEN NAME: Margaret Paul

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Unknown	Records- US Marine Hospital	Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I (a)	1- Adenocarcinoma of prostate	Unknown
DUE TO (b)	2- Hypertensive cardiovascular disease	Unknown
DUE TO (c)	3- Uremia	Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 19, 1949, *to* July 22, 1949, *that I last saw the deceased alive on* July 22 1949, *and that death occurred at* 8:45P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J.P. van Ackeren M.D.	US Marine Hospital, Balto, Md.	7/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Medical Director	7/26	HOLY CROSS CEM.	A.A.Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949	Huntington Williams, M.D.	Elizabeth Herbert Inc.	115 E. West St.

Officer in Charge

VS 150

5TB

G76579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

743

G76579

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HADDAWAY, GEORGE

2. DATE OF DEATH July 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL

c. Length of stay in Baltimore 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1124 ABBOTT COURT

10-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	Married	JUNE 5, 1874	75	1	19

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN

10B. KIND OF BUSINESS OR INDUSTRY David Hill Pk Lot

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME UNKNOWN

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Libbie Haddaway ADDRESS Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Auricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

DUE TO

(B) Myocardial degeneration

DUE TO

(C) Hypertensive cardiovascular disease ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 22, 1949 *to* July 24, 1949 *that I last saw the deceased alive on* July 24, 1949, *and that death occurred at* 11 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Gene V. Mattin M. D. — 23B. ADDRESS Mercy Hospital — 23C. DATE SIGNED July 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE July 28/49 — 24C. NAME OF CEMETERY OR CREMATORY Leader Hill — 24D. LOCATION (City, town, or county) (State) B.A.Co. Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR Elmer W. Conklin — ADDRESS 924 E. Lanv St

VS 150

93D

G76580
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76580

1. NAME OF DECEASED (Type or Print): ALTON V. BREWSTER

2. DATE OF DEATH: July 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. 5 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 730 E. Pratt Street 4-01

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: JULY, 1924
9. AGE (In years last birthday): 25 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEAMAN
10B. KIND OF BUSINESS OR INDUSTRY: MERCHANT MARINE
11. BIRTHPLACE (State or foreign country): MAINE
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HARRY BREWSTER
14. MOTHER'S MAIDEN NAME: BERTHA SHANNON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: FLAGG FUNERAL HOME ADDRESS: DENNYVILLE, MAINE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Alcoholism
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE: 7/25/49
24C. NAME OF CEMETERY OR CREMATORY: HILLSIDE
24D. LOCATION (City, town, or county) (State): EASTPORT MAINE

DATE RECEIVED BY LOCAL REGISTRAR: JUL 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Am Cook Inc. ADDRESS: 1217 St Paul St.

VS 151

77c

G76581

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76581 Registered No.

1. NAME OF DECEASED (Type or Print) MARY WOHLFART

2. DATE OF DEATH 7-22-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 831 S. BOULDIN ST.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 7-6 11
D. STREET ADDRESS (If rural, give location) 831 S. BOULDIN ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
FEMALE	WHITE	WIDOWED	OCT. 31, 1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	HOUSE-WORK.	GERMANY	U.S.A.

13. FATHER'S NAME: AUGUST STOLP

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT: CATHERINE WOHLFART ADDRESS: 831 S. BOULDIN ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arterio-sclerosis	?
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Chronic myocarditis and myocardial degeneration	?
	DUE TO (C) Chronic bronchitis	2 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Hemiplegia, right	3 months

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 20, , 1948, *to* July 22, , 1949, *that I last saw the deceased alive on* July 22, 19 49, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
I. B. Bronushas, M.D.	3037 O'Donnell St	7-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7-26-49	SACRED HEART CEM.	GERMAN HILL RD., MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949	Huntington Williams, M.D.	Charles L. Zeiler	901 S. Conkling St.

937

G76582

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

#43 G76582

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Gertrude Stone

2. DATE OF DEATH: 24 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): City Hospital (DOA)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 819 S. ROBINSON ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	SINGLE	8-23-09.	39				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		BALTIMORE, MD.	U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chrnic glomerular nephritis
DUE TO Myocardial degeneration
Hypertensive cardiovascular disease
CPC

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
Wm. H. Kammer, J. M.D.		24/VII/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7-26-49.	SACRED HEART CEM	GERMAN HILL RD. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 25 1949	Huntington Williams, M.D.	Charles L. Zeiler 901 S. Conkling St.

VS 7st

1310

Correct age is especially important. Physician, please write plainly.

G76583 OLIVE DIRST 50 G76583

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Dirst, Olive (Mrs. John Calvin)

2. DATE OF DEATH: July 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): the Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Bloom Field
D. STREET ADDRESS (If rural, give location): 29 Barnett St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W	Married	Feb. 3 1914	35		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Pennsylvania	United States

13. FATHER'S NAME: Louis Smith

14. MOTHER'S MAIDEN NAME: Elizabeth Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the esophagus with metastasis, — INTERVAL BETWEEN ONSET AND DEATH: 14 mo.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Passive congestion of lungs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
11-24-48	Carcinoma of the esophagus with metastasis	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 4, 1949 *to* July 5, 1949, *that I last saw the deceased alive on* July 5, 1949, *and that death occurred at* 9:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. F. Cox 3d, M.D. M. D.	Union Memorial Hospital	7/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	July 25-1949	Evergreen cemetery	Duncannon Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 25 1949	Huntington Williams, M.D.	William Cook Inc.	1217 St. Paul St. Baltimore Md.

VS 150

46a

76584

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 1 G76584

Registered No.

1. NAME OF DECEASED (Type or Print): ELIZABETH MAGDALENE PFEIFER

2. DATE OF DEATH: JULY 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2781 ALAMEDA BLVD.

c. Length of stay in Baltimore: *** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE,
D. STREET ADDRESS (If rural, give location): 2781 ALAMEDA BLVD. 9-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	WIDOWED	AUGUST 15,1865	83 84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	******	PA.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
VALENTINE ARNOLD	MARY--------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
			MRS.JAY C.SMITH,2781 ALAMEDA BLVD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 1½ hr

DUE TO

(B) Enlarged Heart, Arterio Sclerosis, Hypertension — 4 Mo

DUE TO:

(C) Chronic Interstitial Nephritis — 4 Mo

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 25, 1949, *to* July 25, 1949, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
I Sa Stevens M. D.	2818 Harford Rd	7-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
REMOVAL	JULY 25,1949	ST.MARY'S CEMETERY	PITTSBURGH, PA.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
JUL 26 1949	Tunstington Williams, M.D.	WM.J.TICKNER &SONS, NORTH & PA. AVES BALTO., MD.

VS 150

Correct age is especially important. Typewrite or print plainly.

131a

Taken in by watchman ✓ X

76585

BALTIMORE CITY HEALTH DEPARTMENT 3 3 ✓

CERTIFICATE OF DEATH

G76585

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Mary alice Somers

2. DATE OF DEATH 7/24/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sydenham Hospital

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) [redacted] HALETHORPE
D. STREET ADDRESS (If rural, give location) 5729 1st Ave.

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow | 8. DATE OF BIRTH 19 Aug 1892 | 9. AGE (In years last birthday) 56 | If Under 1 Year: Months 11, Days 12 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 10B. KIND OF BUSINESS OR INDUSTRY HOME | 11. BIRTHPLACE (State or foreign country) Baltimore | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ZACHARY Durham | 14. MOTHER'S MAIDEN NAME MARY E. SPURRIER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | (If yes, give war or dates of service) NONE | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Harry McCabe ADDRESS 7307 School Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Probable Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Arteriosclerosis
DUE TO
(C) Diabetes — 1 yr.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION No | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) None | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/23/ , 1949 *to* 7/24/ , 1949, *that I last saw the deceased alive on* , 19 , *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE James E. Gamble Jr. M.D. | 23B. ADDRESS Sydenham Hospital | 23C. DATE SIGNED 7/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 7-27-49 | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR JUL 26 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR George L. Schwab ADDRESS 210 Frederick Ave

VS 150

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~~76586~~ 76586 ✓ G76586

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

Registered No.

1. NAME OF DECEASED (Type or Print) Anna D. Gronberg

2. DATE OF DEATH 7-23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 308 South Clinton Street

c. Length of stay in Baltimore — Yrs. / Mos. / Days: Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26 10
D. STREET ADDRESS (If rural, give location) 308 South Clinton Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	9-23-1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Maryland	U.S.A.

13. FATHER'S NAME: Conrad Horness

14. MOTHER'S MAIDEN NAME: Elizabeth Diehl ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Unknown	Ernest Gronberg	308 S.Clinton St. Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchio-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Cerebral-hemmorhage with paralysis — abt 1 yr.

DUE TO

(C) arteriosclerosis — ?.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 1949 *to* July 23, 1949, *that I last saw the deceased alive on* July 22, 1949, *and that death occurred at* 5:25 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. T. Klemes M. D.	2623 E. Monument St	July 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-26-1949	Mount Carmel Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 26 1949	Huntington Williams, M.D.	Lilly & Zeiler Inc.	403 S.Wolfe St. Balto.

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76587 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ISADORE SILVERSTEIN

2. DATE OF DEATH 7-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4613 Park Heights Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt Sinai Home

c. Length of stay in Baltimore 44 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-16
D. STREET ADDRESS (If rural, give location) 4613 Park Heights Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married		75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Poland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Louis	Mollie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Elias Silverstein - Kenneth Square Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B) Acute Heart failure

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Chronic Myocarditis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-23 1949 *to* _____, 19__, *that I last saw the deceased alive on* 7-25 1949, *and that death occurred at* 10:17 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. L. Silverstein M. D.	2042 Bridle St	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
removal	7-26-49		Brooklyn N.Y.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 26 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Gettysburg Ave

VS 150

937

G76588

BIRTH NO. B.C.H. 30417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76588

1. NAME OF DECEASED (Type or Print) Darlene Kluka

2. DATE OF DEATH July 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General

C. Length of stay in Baltimore Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 20 E. West St. 23-02

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH Aug. 14-1945
9. AGE (In years last birthday) 3 yrs. If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Kluka
14. MOTHER'S MAIDEN NAME Francis Nicolaus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS Francis Kluka - 20 E. West St.

MEDICAL CERTIFICATION

Correct age is especially important. Physicians, please write plainly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Atrophy
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED July 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July-26-1949
24C. NAME OF CEMETERY OR CREMATORY Oaklawn
24D. LOCATION (City, town, or county) (State) Eastern Ave. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 26 1949
REGISTRAR'S SIGNATURE Carrington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Krause Funeral Home 1216 S. Charles St. 30

VS 151

76589

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76589

1. NAME OF DECEASED (Type or Print): FRANK EDGAR WAGNER

2. DATE OF DEATH: July 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital
Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-2
D. STREET ADDRESS (If rural, give location): Gilman Apts. Calvert & 31st Sts.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Nov. 15, 1870	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	physician	Md.	USA

13. FATHER'S NAME: John Wagner

14. MOTHER'S MAIDEN NAME: Elizabeth Fales

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	SAW	?

17. INFORMANT: Records, ADDRESS: US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the prostate with metastasis to liver — Interval between onset and death: Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis, generalized — Interval between onset and death: Unknown

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 12, 1949, *to* July 24, 1949, *that I last saw the deceased alive on* July 24 1949, *and that death occurred at* 12:25 AM, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Medical Director M.D.	US Marine Hospital, Balto, Md.	7/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/27/49	Rohrer	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 26 1949	Huntington Williams, M.D.	Wilson Col Dru	1219 E Fayette St

VS 150

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76590

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76590 Registered No.

1. NAME OF DECEASED (Type or Print) KATHERINE MADDEN

2. DATE OF DEATH July 23,1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3516 Frankford Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 3516 Frankford Avenue 27-44

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Female	White	Widowed	Feb. 17, 1865	84				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	

13. FATHER'S NAME Frederick King

14. MOTHER'S MAIDEN NAME Margaret Kneisman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Edward Madden	3516 Frankford Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ch Myocarditis DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 4 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypostatic Pneumonia DUE TO

(C) Fract Hip. (Healed) 2 mo

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senility

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	—	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 19 49 *to* July 23, 19 49 *that I last saw the deceased alive on* July 22, 19 49 *and that death occurred at* 2 30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
H Hardesty	3805 Belair Rd	July 25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 26,1949	Parkwood	Parkville Balto.Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 26 1949	Thurlington Williams, M.D.	William Cook, Inc.	1217 St. Paul St.

VS 150

937

CERTIFICATE CORRECTED 7-26-49

76591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76591

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Oscar Livesay

2. DATE OF DEATH: July 24 '49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balt 6

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 68 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1815 Mt. Royal Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	11-1881	67 Yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Odd Jobs		Md.	

13. FATHER'S NAME: Giles Livesay

14. MOTHER'S MAIDEN NAME: Agnes Bleakney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of stomach — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 18 '49 *to* July 24, 1949 *that I last saw the deceased alive on* July 24 19 49 *and that death occurred at* 11½ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip D. Wagley M. D.	JOHNS HOPKINS HOSP.	7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/27/49	Green Mount Cemetery	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 26 1949	Huntington Williams, M.D.	Wilhorn & Son Inc	1217 E. Fayette St

VS 150

46C

76592

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

20.0

G76592

Registered No.

1. NAME OF DECEASED (Type or Print) Stanley Wisniewski

2. DATE OF DEATH July 23, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home And Hospital

c. Length of stay in Baltimore 28 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 506 N. Castle St. 7-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	May 8, 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Grave Digger	Grave-Digging	Poland	U.S.

13. FATHER'S NAME Karl Wisniewski

14. MOTHER'S MAIDEN NAME Mary Pietrawski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Miss D. Walker Church Home & Hosp.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc, It means the disease, injury or complication which caused death.)

(A) Carcinoma of liver — Interval between onset and death: 7 weeks

DUE TO

(B) Arteriosclerosis — 15 years

DUE TO

(C) Arteriosclerotic Heart Disease — 10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from July 15, 1949 to July 23, 1949, that I last saw the deceased alive on July 23, 1949, and that death occurred at 8:50 P.M., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James F. Means M.D. M.D.	Church Home & Hospital	July 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	7-27-49	Holy Rosary Cem	Baltimore County

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 26 1949	Huntington Williams, M.D.	John M. Weber	4010 S. Chester St. Balto. Md.

VS 150

46F

IFICATE CORRECTED 1-26-49

CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76593

6593
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Wladyslaw (WALTER) BIELEK

2. DATE OF DEATH July 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 8 North Ann Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 43 7 14 4 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore,
D. STREET ADDRESS (If rural, give location) 8 North Ann Street 6-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	July 15 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Bielik

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-03-2097

17. INFORMANT Mrs. Frances Bielik wife ADDRESS 8 N. Grant St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary disease

DUE TO

(B) Chronic myocardial degeneration

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED July 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-28-49	Holy Rosary Cem	Baltimore County

DATE RECEIVED BY LOCAL REGISTRAR JUL 26 1949

REGISTRAR'S SIGNATURE [illegible] Washington Nottingham, M.D.

25. FUNERAL DIRECTOR John M. Weber ADDRESS 401 S. Chester St

93D

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76594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76594

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM FARLOW

2. DATE OF DEATH: July 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3100 Chesley Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3100 Chesley Ave. 27-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	single	about March 24, 1878	about 71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired stenographer
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Hugh Farlow

14. MOTHER'S MAIDEN NAME: Elizabeth -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Sophia A. Clunet ADDRESS: 3100 Chesley Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Arteriosclerotic C. V. Disease	1 wk.
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr. 10, 1949, *to* July 24, 1949, *that I last saw the deceased alive on* July 24, 1949, *and that death occurred at* 6:20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Nathan Janney M. D.
23B. ADDRESS: 7101 Harford Rd.
23C. DATE SIGNED: 7/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/27/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

93D

G76595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76595

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William H. Lotz

2. DATE OF DEATH 7/24/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Md
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md 15-09
d. STREET ADDRESS (If rural, give location) 2119 Lyndhurst St

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2119 Lyndhurst St

3c. Length of stay in Baltimore — Yrs. / Mos. / Days

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug. 1, 1883
9. AGE (In years last birthday): 65
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Agent
10b. KIND OF BUSINESS OR INDUSTRY: Life Insurance

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Henry Lotz

14. MOTHER'S MAIDEN NAME: Laura Virginia Lange

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 212-18-7289

17. INFORMANT: Mrs. F. M. Lotz, ADDRESS: 2119 Lyndhurst Ave.

MEDICAL CERTIFICATION

Correct age is especially important. Physicians: please

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23a. SIGNATURE C. F. Lehmann M.D.
23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23c. DATE SIGNED 7/24/49

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 7/27/49
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
24d. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. Vernon Lemmon
ADDRESS: 4611 Pk. Heights Ave.

VS 151

94a

G76596
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

60

G76596
Registered No.

1. NAME OF DECEASED (Type or Print): NELLIE M. PUMPIAN

2. DATE OF DEATH: July 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Mount Nursing Home Nortonia Road

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1928 E Madison St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. Last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	July 15, 1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore Md	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harris Mitnick	Schreiber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Jerome H. Pumpian	4122 Forest Pk. Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Pyelo Nephritis	1 week
DUE TO (B)	Diabetes Mellitus	6 years
DUE TO (C)	General arteriosclerosis	6 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/15, 1946 *to* 7/25, 1949, *that I last saw the deceased alive on* 7/25, 1949, *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	23 W Eutaw St	7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-27-49	Beth Tfiloh Cong	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 26 1949	Emmett Worthington Williams, M.D.	S. Levinson & Bros.	1124-26 W North Avenue

VS 150

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G76597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76597

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Michael V. MARKIEWICZ

2. DATE OF DEATH July 24 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2223 E. Pratt St.

C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto
D. STREET ADDRESS (If rural, give location) 2223 E. Pratt St.

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH
9. AGE (In years last birthday) 83 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John M. Markiewicz
14. MOTHER'S MAIDEN NAME Catherine Rulewicz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Francis Markiewicz ADDRESS 2223 E Pratt St

MEDICAL CERTIFICATION

CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Senility	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	Arterio-sclerosis with gangrene toes + feet	3 years
	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/25, 1946, to 7/24, 1949, *that I last saw the deceased alive on* 6/18/49, *and that death occurred at* 12 45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE Sigmund R. Nowak M. D.
23B. ADDRESS 408 S. Patt. Pk. Ave.
23C. DATE SIGNED 7-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 28-49
24C. NAME OF CEMETERY OR CREMATORY Holy Rosary
24D. LOCATION (City, town, or county) (State) Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR JUL 26 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm. S. Fialkowski ADDRESS 2007 Eastern Ave

VS 150

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G76598

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76598 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANNA L. PARKS (Annie L.Parks)

2. DATE OF DEATH 7-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL Hospital
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2438 EDMONDSON AVE #23

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 7-4-1866 | 9. AGE (In years last birthday) 82 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress
10B. KIND OF BUSINESS OR INDUSTRY Dressmaker.

11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JAMES H. PARKS
14. MOTHER'S MAIDEN NAME ANNE MARIE MORRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT ELIZABETH CAMPER ADDRESS 4438 Edmondson Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) JAUNDICE. - CAUSE unknown 14 days.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 14, 1949, to July 24, 1949; *that I last saw the deceased alive on* July 24, 1949, *and that death occurred at* 1:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Richard G. Martin M. D.
23B. ADDRESS Maryland Gen. Hosp.
23C. DATE SIGNED 7-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-28-49
24C. NAME OF CEMETERY OR CREMATORY New Cathedral
24D. LOCATION (City, town, or county) (State) Edmondson Ave, Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 26 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR George J. Ruth INC ADDRESS 185 Harford Ave 125B

VS 150

G76599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

G76599

Registered No.

1. NAME OF DECEASED (Type or Print) Otha May Horton

2. DATE OF DEATH July 27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1551 Leslie St

c. Length of stay in Baltimore 9 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Balto Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 15 01
D. STREET ADDRESS (If rural, give location) 1551 Leslie St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Single	July 19, 1932	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY School

11. BIRTHPLACE (State or foreign country) Penna.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Otho Horton

14. MOTHER'S MAIDEN NAME Augusta Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Otho Horton ADDRESS 1551 Leslie St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Arthritis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH 1 yr?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 6, 1949 *to* July 27, 1949, *that I last saw the deceased alive on* July 29, 1949, *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE William Frey M. D.

23B. ADDRESS 1928 Penna Ave

23C. DATE SIGNED July 26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/27/49

24C. NAME OF CEMETERY OR CREMATORY Mt Auburn

24D. LOCATION (City, town, or county) (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 26 1949

REGISTRAR'S SIGNATURE Hunter Jon Williams, M.D.

25. FUNERAL DIRECTOR Geo. G. Kelson ADDRESS 1303 Presstman St.

VS 150

598

G76600

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

560 3

G76600 Registered No.

1. NAME OF DECEASED (Type or Print): MRS. ROSALIA BRANDNER

2. DATE OF DEATH: July 23, '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BON SECOURS HOSP.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Severn Md
D. STREET ADDRESS (If rural, give location): Quarterfield Road

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: June 7 1891
9. AGE (In years last birthday): 58 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.): 7 16
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Louis Weyforth
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr Thelma Franklin ADDRESS: Severn Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis of Lungs, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 36 HRS.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: July 21, '49
19B. MAJOR FINDINGS OF OPERATION: Large Ventral Hernia - Rt. Side.
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 7-20, 1949 *to* 7-23, 1949, *that I last saw the deceased alive on* 7-23, 1949, *and that death occurred at* 3:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph R. Dolce M. D.
23B. ADDRESS: Bon Secours Hosp.
23C. DATE SIGNED: 7-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 27/49
24C. NAME OF CEMETERY OR CREMATORY: Balto Cem
24D. LOCATION (City, town, or county) (State): Balto

DATE RECEIVED BY LOCAL REGISTRAR: JUL 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ulman Funeral Home ADDRESS: 2008 Arlington Ave

VS 150

122a

G76601

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3 r 0

G76601

Registered No.

1. NAME OF DECEASED (Type or Print): GRANT McCAIN

2. DATE OF DEATH: July 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. 2 Mos. yrs Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1116 E. Lombard Street 3-0 r

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	M.	3-23-16	33		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Phoenix Smelting Co

11. BIRTHPLACE (State or foreign country): Union Co. N. C.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Grant McCain

14. MOTHER'S MAIDEN NAME: Dinah Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Robert McCain ADDRESS: Kannapolis N.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH

(B) Acute alcoholism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl Rogers M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 7-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): B.

24B. DATE: 7-26-49

24C. NAME OF CEMETERY OR CREMATORY: Elmwood Cem.

24D. LOCATION (City, town, or county) (State): Charlotte N. C.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 26 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Samuel W. Sullivan Jr. ADDRESS: 77c 1011 N. Arlington Ave

VS 151

G76602

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

237 G76602
Registered No.

1. NAME OF DECEASED (Type or Print) Ruby Newton

2. DATE OF DEATH 7-25-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Univ. Hosp (Maryland)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY 23
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 938 Booth 1F-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Negro	married	12-16-1923	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Allen
14. MOTHER'S MAIDEN NAME: Mattie Ellis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hosp. Records — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Brain Tumor
DUE TO
(B) (over)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 6-6-49
19B. MAJOR FINDINGS OF OPERATION Brain Tumor Left Lobe - Temporal
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 July, 1949 *to* 25 July, 1949 *that I last saw the deceased alive on* 25 July, 1949 *and that death occurred at* 6:34 *m., from the causes and on the date stated above.*

23A. SIGNATURE John A. Stowell M. D.
23B. ADDRESS Univ. Hosp.
23C. DATE SIGNED 7-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify) B.
24B. DATE 7-28-49
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary
24D. LOCATION (City, town, or county) (State) B.A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 26 1949
REGISTRAR'S SIGNATURE Timothy Jos. Williams, M.D.
25. FUNERAL DIRECTOR Samuel W. Sullivan Jr. — ADDRESS 561) 1811 W. Pilington Ave

VS 150

76603

BIRTH NO. B.C. 49-14864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

776

G76603

Registered No.

1. NAME OF DECEASED (Type or Print) Debra Mae Singer

2. DATE OF DEATH July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOCTOR'S HOSPITAL

c. Length of stay in Baltimore — Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE [redacted] B. COUNTY [redacted] Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Maryland

D. STREET ADDRESS (If rural, give location) 1439 Mt. Royal Avenue 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Infant	July 20, 1949	0		1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Maryland	U. S. A.

13. FATHER'S NAME: Roy Buchman Singer

14. MOTHER'S MAIDEN NAME: Elva May Early

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PREMATURE BIRTH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 20, 19 49 *to* July 21, 19 49, *that I last saw the deceased alive on* July 21, 19 49 *and that death occurred at* 2.0 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	2730 N. Charles St	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		JOHNS HOPKINS MEDICAL SCHOOL	JUL 25 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 26 1949	Huntington Williams, M.D.	[illegible]	

VS 150

159

G76604

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76604
Registered No.

1. NAME OF DECEASED (Type or Print) Rose M. KELLEY. | 2. DATE OF DEATH July 24.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE | COUNTY
B. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto md
C. STREET ADDRESS (If rural, give location) 1128 Ward St. 21-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	Feb 22 1875	74.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife.	—	Balto md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Michael J. Kelley	Mc Connell.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ROBERT J. KELLEY ADDRESS Same
✓	✓	✓	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) none

DUE TO

(C) none

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8/26, 19 49 *to* 7/24, 19 49, *that I last saw the deceased alive on* 7/24, 19 49, *and that death occurred at* 4:15 *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Benjamin Miller MD M. D.	1020 Wilkens Ave	7/26/49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/28.	Mount Cathedral	Edmondson Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 26 1949		Chas W Tashmanshire	703 McHenry St.

VS 150

G76605

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 972-0

Registered No. G76605

N-968

1. NAME OF DECEASED (Type or Print): Anna Drebing

2. DATE OF DEATH: July 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3535 Lyndale St.

8-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M F	W	widow	Sept 26,1912	36 57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crown Cork & Seal

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Prell

14. MOTHER'S MAIDEN NAME: Julia Ruth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-20-7402

17. INFORMANT: Mehrle A. Keil ADDRESS: 703 N. Streeper Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia, Carbon monoxide

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3535 Lyndale St.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: ~~approx. July 20, 1949~~ ? m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? ~~All burners on gas stove on but unlit~~ X

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: William J. MacDermott M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: July 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 27, th

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State): Belair Rd

DATE RECEIVED BY LOCAL REGISTRAR: JUL 26 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Schimunek Funeral Home Inc ADDRESS: 2601 E. Madison Street

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76606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 93 G76606

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harold Wilton Smith

2. DATE OF DEATH: July 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Med. Opl 6

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Md — 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Cecil
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Port Deposit
D. STREET ADDRESS (If rural, give location): Rt 1 Box 67

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 9-22-28
9. AGE (In years last birthday): 20 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William A. Smith

14. MOTHER'S MAIDEN NAME: Irene Kenney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia — Interval between onset and death: 3 yrs.
DUE TO
(B) Nephritis
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-18-, 1949 *to* 7-26-, 1949, *that I last saw the deceased alive on* 7-26-, 1949 *and that death occurred at* 4:15 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Philip S. Wagley, M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 29, 1949
24C. NAME OF CEMETERY OR CREMATORY: Asbury
24D. LOCATION (City, town, or county) (State): Ft. Deposit, Md. Rd.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Lee A. Patterson & Son, Perryville, Md.

VS 150

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76607

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 75 44 G76607

Registered No.

1. NAME OF DECEASED (Type or Print): Antonia Mujica

2. DATE OF DEATH: July 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Florida
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Key West
D. STREET ADDRESS (If rural, give location): 728 Elizabeth St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 3-28-45
9. AGE (In years last birthday): 4 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Florida
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Onelis Mujica
14. MOTHER'S MAIDEN NAME: Maria Perez

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure
DUE TO
(B) Congenital heart disease
DUE TO
(C) Tricuspid atresia
TRICUSPID ATRESIA

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: 7/22/49
19B. MAJOR FINDINGS OF OPERATION: Tricuspid atresia
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/21, 1949, to 7/26, 1949, *that I last saw the deceased alive on* 7/26, 1949, *and that death occurred at* 11:20 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: July 29 49
24C. NAME OF CEMETERY OR CREMATORY: Key West
24D. LOCATION (City, town or county) (State): Fla.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949
REGISTRAR'S SIGNATURE: [signature] Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ulloa Funeral Home — ADDRESS: 2008 Orleans

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G76608 ✓ 76608 43 G76608

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): CATHERINE MIHM KRUMHOLTZ

2. DATE OF DEATH: July 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 530 East 23rd St.
C. Length of stay in Baltimore: Yrs. 9 Mos. 08 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 530 East 23rd St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	White	Widow	Aug. 7, 1870	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Andrew Mihm
14. MOTHER'S MAIDEN NAME: Barbara Meinkratz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mycorditis — INTERVAL BETWEEN ONSET AND DEATH: about 7 yr
DUE TO
(B) Arteriosclerosis — about 8 yrs
DUE TO
(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1948, 19__, to July 26, 1949 *that I last saw the deceased alive on* July 26, 1949 *and that death occurred at* 11 A m. *from the causes and on the date stated above.*

23A. SIGNATURE: Weller & Tebbett M. D.
23B. ADDRESS: 222 Garrison Blvd
23C. DATE SIGNED: July 26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/29/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1217 St. Paul St.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen Mack

2. DATE OF DEATH: July 26/1949

3. PLACE OF DEATH: a. Baltimore City, Maryland — Womens clinic

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Florida — B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Okeechobee — D. STREET ADDRESS (If rural, give location)

5. SEX: Female — 6. COLOR OR RACE: white — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH: 9-3-99 — 9. AGE (In years last birthday): 49 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): New York — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alonzo DeGraw

14. MOTHER'S MAIDEN NAME: Alice Van Duine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO (A) Chronic pyelonephritis — 3 wks.

DUE TO (B) Monilia septicemia — 10 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Epidermoid carcinoma cervix uteri — several yrs 4 yrs.

DUE TO (C) Diabetes mellitus

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Thrombophlebitis, left leg. — 5 days

19A. DATE OF OPERATION: 6-29-49 — 19B. MAJOR FINDINGS OF OPERATION: Carcinoma of cervix extending to vagina, bladder, uterus

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m. — 21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/21 *to* 7/26, 1949, *that I last saw the deceased alive on* 7/26, 1949, *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Laurence R. Wharton, M. D. — 23B. ADDRESS: JOHNS HOPKINS HOSPITAL — 23C. DATE SIGNED: 7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 7/28/49 — 24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Park — 24D. LOCATION (City, town, or county) (State): Baltimore Co Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Wilson Co — ADDRESS: 2211 Pennsylvania Ave

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Janet Lee McRobie X

2. DATE OF DEATH: July 26 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland. Harriet Lane
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Garrett
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Finzel
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White		9-20-42	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Elsie McRobie

14. MOTHER'S MAIDEN NAME: Mae Upfold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
			JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure - Pulmonary Hemorrhage

DUE TO

(B) Cardiac Failure - Multiple Thromboses

DUE TO

(C) Congenital Heart Disease - Cyanotic Type Life Transposition Great Vessels

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/16/49	Transposition of Great Vessels	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/8 *to* 7/26 *, 1949, that I last saw the deceased alive on* 7/26 *, 1949, and that death occurred at* 9 45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harrison Clark Spencer M. D.	JOHNS HOPKINS HOSPITAL	7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/29/49	Mt Zion Cemetery	Piedmont W. Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 27 1949	Huntington Williams, M.D.	Boal Funeral Service	111 Churchill Piedmont W. Va

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G76611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 50

G76611

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ROSE ROSENSTEIN | 2. DATE OF DEATH 7-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Levindale

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-01
D. STREET ADDRESS (If rural, give location) 820 Chauncey Ave

c. Length of stay in Baltimore 50 Yrs. ~~Mos.~~ Days

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH | 9. AGE (In years. If under 1 year, Months, Days. If under 24 hours, Hours, Min.) 63

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Russia | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Philip Kader | 14. MOTHER'S MAIDEN NAME Lena

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Frenda Silberstein ADDRESS 820 Chauncey Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Septicemia — INTERVAL BETWEEN ONSET AND DEATH few weeks
DUE TO
(B) undetermined origin
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Parkinson Syndrome — 6 years

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-29 1949 *to* 7-26 1949, *that I last saw the deceased alive on* 7-26 1949, *and that death occurred at* 9:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Henry Nagel M. D. | 23B. ADDRESS Levindale Home | 23C. DATE SIGNED 7-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7-27-49 | 24C. NAME OF CEMETERY OR CREMATORY Mishkan Israel | 24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 27 1949 | REGISTRAR'S SIGNATURE (Deputy for Williams, M.D.) | 25. FUNERAL DIRECTOR Jack Lewis Inc | ADDRESS 2100 Eutaw Pl

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G76612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76612

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Kling

2. DATE OF DEATH: 7-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2906 Auchentoroly Ter

C. Length of stay in Baltimore: 47 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-04
D. STREET ADDRESS (If rural, give location): 2906 Auchentoroly Terrace

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 66
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Morris Kling ADDRESS: 2906 Auchentoroly Ter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Carcinomatosis — Interval between onset and death: 3 months
DUE TO
ANTECEDENT CAUSES
(B) Carcinoma of Stomach — 1 year
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1/24/49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of stomach
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/15/48 *to* 7/26/49, *that I last saw the deceased alive on* 7/26/49, *and that death occurred at* 8:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1320 Eutaw M
23C. DATE SIGNED: 7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-27-49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Hebrew
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

46B

G76613

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76613 Registered No.

1. NAME OF DECEASED (Type or Print): ROBERT SILVERMAN

2. DATE OF DEATH: 7/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

C. Length of stay in Baltimore: 43 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balto. city
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-11
D. STREET ADDRESS (If rural, give location): 3411 Calloway Ave

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M

8. DATE OF BIRTH | 9. AGE (In years last birthday): 46 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Merchant
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph

14. MOTHER'S MAIDEN NAME: Anna Leah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Anna Silverman -3411 ADDRESS: Calloway Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary infarction
DUE TO
(B) Congestive failure + HCVD
DUE TO
(C) ASHD c previous myocardial infarct

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/24 *, 19*49 *to* 7/26 *, 19*49 *that I last saw the deceased alive on* 7/26 *, 19*49*, and that death occurred at* 1:40 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: William Krakower M. D. | 23B. ADDRESS: Sinai Hospital | 23C. DATE SIGNED: 7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 7-27-49 | 24C. NAME OF CEMETERY OR CREMATORY: Southern Ave | 24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Jack Levin Inc. ADDRESS: 2100 Eutaw Pl

VS 150

937

76617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 G76614 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Samuel H. Applestein

2. DATE OF DEATH 7/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home

C. Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1815 No Payson St

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH
9. AGE (In years last birthday) 75 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Benjamin
14. MOTHER'S MAIDEN NAME Anna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Bertha Cohen ADDRESS 1815 No Payson St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular Accident
DUE TO
(B) Hyp. As. & V.D.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bilateral Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 25, 1949 to July 26, 1949, *that I last saw the deceased alive on* July 26, 1949, *and that death occurred at* 7:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Leonard Kol M. D.
23B. ADDRESS 7 Penn Lane
23C. DATE SIGNED 7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-27-49
24C. NAME OF CEMETERY OR CREMATORY Hebrew Herring Run
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 27 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

VS 150

937

76615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76615

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clinton L. Roche

2. DATE OF DEATH July 26 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore City Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1407 Sulphur Spring Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Male	White	Married	6-7-1869	80	1	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired.		Maryland	

13. FATHER'S NAME William

14. MOTHER'S MAIDEN NAME Jane Wright.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) BILATERAL PLEURAL EFFUSION
DUE TO (B) PULMONARY EDEMA
DUE TO (C) DEGENERATIVE ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE
CARDIAC ENLARGEMENT

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/8, 1949, to 7/26, 1949, *that I last saw the deceased alive on* 7/26, 1949, *and that death occurred at* 5:50 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Corbin H. Shaw M. D.	St. Agnes Hosp	7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 29 1949	Lorraine	Baltimore County

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 27 1949	Huntington Williams, M.D.	Frederick A. Cole	937

VS 150

76616

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76616

1. NAME OF DECEASED (Type or Print): BOOKER, IRVING MEANDER
2. DATE OF DEATH: 7-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.
C. Length of stay in Baltimore: 64 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-01
D. STREET ADDRESS (If rural, give location): 641- George St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	M	7-15-85	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): porter
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Henry Booker
14. MOTHER'S MAIDEN NAME: Lydia Coleman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give War or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: wife - Cliz. Booker ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Esophageal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.
DUE TO
(B) Esophageal Varices — ?
DUE TO
(C) Cirrhosis of liver — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
arteriosclerotic H.D.

19A. DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): 0
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 0
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 0
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: 0
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? 0

22. *I hereby certify that I attended the deceased from* 7-23-, 1949, *to* 7-23-, 1949, *that I last saw the deceased alive on* 7-23-, 1949, *and that death occurred at* 9 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: W.A. Williams M.D.
23B. ADDRESS: Univ. Hosp.
23C. DATE SIGNED: 7-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	7-27-49	Mt. Auburn Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949
REGISTRAR'S SIGNATURE: Twitty for Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Kate R. Williams ADDRESS: 992 W. Lafayette Ave

VS 150

124B

G76617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76617

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harriett Gibbs

2. DATE OF DEATH July 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Little Sisters of the Poor Home for the Aged

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1200 Valley St. 10-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	W.	June 1, 1867	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Charles Co. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Nathaniel Somerville

14. MOTHER'S MAIDEN NAME Rachael —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.

16. SOCIAL SECURITY NO. None

17. INFORMANT Lillian Symonds ADDRESS 1200 Valley St. Balto 2-Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH 1 yr.

DUE TO

ANTECEDENT CAUSES

(B) Metastasis in Liver — 4 months

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10 -, 1949 *to* July 24, 1949 *that I last saw the deceased alive on* July 24 1949. *and that death occurred at* 2:35 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E Gill Hall M. D.	1631 E. North Ave	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	7-27-49	St. Marys Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 27 1949	Huntington Williams, M.D.	Mrs Kate L Williams	933 N. Lafayette St

VS 150

46B

G76618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76618

BIRTH NO. B.C. 49-21974

1. NAME OF DECEASED (Type or Print) Kenneth BERT Harrison Jr.

2. DATE OF DEATH 25 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore — Yrs. Life, Mos., Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3103 Keswick Road 13-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W		Jan. 20-1949		6	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) baby

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Kenneth B Harrison

14. MOTHER'S MAIDEN NAME Mary L. McKenney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Kenneth B Harrison ADDRESS 3103 Keswick Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Postoperative hyperthermia

DUE TO

(B) Drainage of distended subarachnoid space

DUE TO

(C) Birth intracranial hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 25 July 1949

19B. MAJOR FINDINGS OF OPERATION Distended subarachnoid space

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 19 July, 1949, to 25 July, 1949, *that I last saw the deceased alive on* 25 July, 1949, *and that death occurred at* 6:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Jose A. Alvarez - de Chondens M. D.

23B. ADDRESS University Hospital

23C. DATE SIGNED 25 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 28-1949

24C. NAME OF CEMETERY OR CREMATORY St. Mary's (Hampden)

24D. LOCATION (City, town or county) (State) Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR JUL 27 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Burgee Funeral Home ADDRESS 3631 Falls Road

VS 150

160a

6619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 G76619 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES J. HALL

2. DATE OF DEATH: July 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 911 Edmondson Avenue 18-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Widower	April 1, 1883	66 65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Perry Hall

14. MOTHER'S MAIDEN NAME: Lizzie Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Ethel Robinson ADDRESS: 911 Edmondson Av

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute Cardiac Dilitation	
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].

23A. SIGNATURE: William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 7-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 7-29-49

24C. NAME OF CEMETERY OR CREMATORY: St. John's Cem

24D. LOCATION (City, town, or county) (State): Longgreen, Balto.Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949

REGISTRAR'S SIGNATURE: Timothy for Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Mrs. Frances A. Hemsley 578 W. Biddle

VS 151

95c

G76620 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

44 G76620 Registered No.

1. NAME OF DECEASED (Type or Print) CHARLES SEUBERT

2. DATE OF DEATH 7/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General

c. Length of stay in Baltimore 4y Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8 05

D. STREET ADDRESS (If rural, give location) 1901 E. 20th St #13

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	W	10/4/74	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter

10B. KIND OF BUSINESS OR INDUSTRY Town Bldg

11. BIRTHPLACE (State or foreign country) Balto.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Christian Seubert

14. MOTHER'S MAIDEN NAME Rosina - -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 212-03-8167

17. INFORMANT Mrs Caroline Martin ADDRESS 1901 E 20th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: R Le

DUE TO

(B) Hypertensive Cardiovascular Renal Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Auricular fibrillation

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/26 19 49 *to* 7/26 19 49 *that I last saw the deceased alive on* 7/26 19 49 *and that death occurred at* 5:45 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles J. Blast M. D.	Maryland General	7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 29 49	Balto	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949

REGISTRAR'S SIGNATURE: Minnie Jones for Williams, M.D.

25. FUNERAL DIRECTOR: Philip Herwig Sons ADDRESS: 2024 Eutaw St

VS 150

1310

BIRTH NO. 76621

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 076621

1. NAME OF DECEASED (Type or Print): Mary B.Phaller

2. DATE OF DEATH: July 26,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3318 Noble St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 3318 Noble St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md.
D. STREET ADDRESS (If rural, give location) 3318 Noble Street 76-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Aug.26.1882	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
---	---	Balto. Md.	

13. FATHER'S NAME: Henry Zink

14. MOTHER'S MAIDEN NAME: Eva Ebert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
--	--	--

17. INFORMANT — ADDRESS: Mr.Joseph F.Phaller,3318 Noble St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 3 minutes

DUE TO

ANTECEDENT CAUSES.

(B) Hypertension

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Cardiorenal disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. , 1948, *to* July 26, 1949, *that I last saw the deceased alive on* July 25, 1949, *and that death occurred at* 7:30a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles E. MacMinn M. D.	2911 E. Baltimore St	July 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	July 29/49	Holy Redeemer Cem	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 27 1949	Kimberly for Williams, M.D.	Philip Henry Sons	1024 Orleans St

VS 150

131a

B.C.49-1586

G76622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76622 Registered No.

BIRTH NO. 26452½

1. NAME OF DECEASED (Type or Print) Baby Girl Stinchcomb

2. DATE OF DEATH July 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.
C. Length of stay in Baltimore 1 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balt. Md. 18-03
D. STREET ADDRESS (If rural, give location) 949 W. Lombard St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	July 23, 1949	1 day		1	19	28

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Md.	U.S.A.

13. FATHER'S NAME ~~Carl Hoyt~~ Thomas Henry Stinchcomb

14. MOTHER'S MAIDEN NAME Alice Hoyt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	Mother.	949 W. Lombard St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 33 hrs

DUE TO

(B) Prematurity — 11

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 23, 1949, to July 24, 1949, *that I last saw the deceased alive on* July 23, 1949, *and that death occurred at* 10:23 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. B. Ahkam M.D. M. D.	University Hosp.	7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/27/49	Western Cemetery	Edmondson Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 27 1949	Huntington Williams, M.D.	John J. Townsend	955 Hollins St.

VS 150

159

G76623 ✓201 G76623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 76623

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mildred Elizabeth Alex

2. DATE OF DEATH: July 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4911 LaSalle Avenue

c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-01
D. STREET ADDRESS (If rural, give location): 4911 LaSalle Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3-5-1920
9. AGE (If years, last birthday): 29
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lunchenette
10B. KIND OF BUSINESS OR INDUSTRY: Hutzlers

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Stanford

14. MOTHER'S MAIDEN NAME: Lillian Nelson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-01-1233

17. INFORMANT: Thomas B. Alex ADDRESS: 4911 LaSalle Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial failure acute — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) Hodgkins disease-advanced stage — 3½ years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-15-, 1949 *to* 7-25-, 1949, *that I last saw the deceased alive on* 7-25-, 1949, *and that death occurred at* 4:13 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Joseph E. Muse Jr. M. D.
23B. ADDRESS: 5 West 29th Street
23C. DATE SIGNED: 7-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-28-49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Eastern Ave. Road

DATE RECEIVED BY LOCAL REGISTRAR: 7-27-49
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: The Dippel Bros. 1800 E. Lombard St

VS 150

448.

G76624

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76624

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELMINA VOLZ

2. DATE OF DEATH 7/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hosp

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2502 E. Biddle St.

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 05-21-1880
9. AGE (In years last birthday) 69 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF (What country?) USA

13. FATHER'S NAME John McKay
14. MOTHER'S MAIDEN NAME Helen Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Hospital Records ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Diabetes mellitus

DUE TO (B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/21, 1949, to 7/24, 1949 that I last saw the deceased alive on 7/24, 1949, and that death occurred at 11:30 p m., from the causes and on the date stated above.

23A. SIGNATURE Stanislaus Swirski M. D.
23B. ADDRESS St. Joseph's Hosp.
23C. DATE SIGNED 7/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/27/49
24C. NAME OF CEMETERY OR CREMATORY Mount Carmel
24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 27 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR John C. Miller Inc. ADDRESS 2455 E. Oliver St.

VS 150

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G76625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76625

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph M. Jaeger

2. DATE OF DEATH 7-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2423 E. Lafayette Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2423 E. Lafayette Ave

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH Oct. 13. 1923 | 9. AGE (In years last birthday) 25 yrs | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Jaeger

14. MOTHER'S MAIDEN NAME Elvira Neuman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Joseph Jaeger ADDRESS 2423 E. Lafayette Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: appx 20 mos

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 26 July 1948 *to* 25 July 1949, *that I last saw the deceased alive on* 24 July 1949, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D. | 23B. ADDRESS 1513 N. Milton Ave | 23C. DATE SIGNED 26 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7-28-49 | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer | 24D. LOCATION (City, town, or county) Belair Road (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 27 1949 | REGISTRAR'S SIGNATURE Municipal Registrar, Baltimore, Md. | 25. FUNERAL DIRECTOR John A. Mullin | ADDRESS 2425 E. Oliver St

VS 150 (Rev.)

13C

G76626
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. G76626

1. NAME OF DECEASED (Type or Print): JEAN McLAURIN WATTS WEBER (81-1)
2. DATE OF DEATH: July 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lynchburg
D. STREET ADDRESS (If rural, give location): 2137 Rivermont Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Divorced	April 21, 1911	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—		Lynchburg, Virginia	USA

13. FATHER'S NAME: Robert C. Watts
14. MOTHER'S MAIDEN NAME: Laurie McLaurin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Robert C. Watts, Jr.,	3827 Sheringham Pl. Lynchburg, Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Ruptured esophageal varices
DUE TO
(B) Fatty degeneration of liver
DUE TO
(C) Chronic alcoholism

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: William J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 7-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7-27-49		Lynchburg, Va.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. J. Tickner & Son — ADDRESS: Baltimore Blvd.

VS 151

124a

Dr. A. J. Blechman
5426 Bank St.

G76627

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. G76627 Registered No. G76627

1. NAME OF DECEASED (Type or Print): Joseph Kalbfleisch

2. DATE OF DEATH: July 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 238 S. Highland Avenue

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 238 S. Highland Avenue 26-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
male	white	married	Apr. 28, 1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Shipping Clerk,

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Kalbfleisch

14. MOTHER'S MAIDEN NAME: Theresa Greiser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Mary Kalbfleisch, ADDRESS: 238 S. Highland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — July 11 — INTERVAL BETWEEN ONSET AND DEATH: 1949

DUE TO

(B) Myocardelis — 1949

DUE TO

(C) Arteriosclerosis — 1946

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 11, 1949 *to* July 25, 1949, *that I last saw the deceased alive on* July 25 1949 *and that death occurred at* 10:20 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE: Andrew P. Gladhill M.D.

23B. ADDRESS: 5426 Bank St.

23C. DATE SIGNED: 9/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 7-28-49

24C. NAME OF CEMETERY OR CREMATORY: Moreland Park

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949

REGISTRAR'S SIGNATURE: Countersigned for Williams, M.D.

25. FUNERAL DIRECTOR: Leonard J. Ruck, ADDRESS: 5305 Harford Road.

HH 2-7-1949 VS 150

93D

G76628 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76628

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE E. BERGGREN

2. DATE OF DEATH: July 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4204 Harcourt Road

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4204 Harcourt Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	Feb. 4-1906	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elect. Engineer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Elof Berggren

14. MOTHER'S MAIDEN NAME: Ella

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Elizabeth Berggren ADDRESS 4204 Harcourt

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION, LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: Earl L. Kopp M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 7-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 7-29-49

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

FUNERAL DIRECTOR: Leonard J. Luck

ADDRESS: 5305 Harford

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Dr. Golley G76629 BALTIMORE CITY HEALTH DEPARTMENT 4th G76629

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET M. KOESTER

2. DATE OF DEATH JULY 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2502 Southern Avenue
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2502 Southern Avenue 27-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Feb. 19, 1867	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frederick Segelken
14. MOTHER'S MAIDEN NAME Meta Sasse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Mrs. Henry Beck, 2502 Southern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 1, 1949, to 7/26, 1949, *that I last saw the deceased alive on* 7/26 1949 *and that death occurred at* 4:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Chas. Golley M. D.
23B. ADDRESS 5103 Harford Rd
23C. DATE SIGNED 7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-29-49
24C. NAME OF CEMETERY OR CREMATORY Parkwood
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 27 1949
REGISTRAR'S SIGNATURE [illegible] Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, 5305 Harford Road.

93D

G76630

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

903 G76630
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret Boschen N-8-0

2. DATE OF DEATH: 7-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6420 Reistertown Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Seton Institute

C. Length of stay in Baltimore: 45 yrs. + (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15
D. STREET ADDRESS (If rural, give location): 640 Stamford Road 28-04

5. SEX: F
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 8-20-1858
9. AGE (In years last birthday): 90 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unoccupied
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Nolan
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): --
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT: The Seton Institute ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — CERTIFICATION APPROVED — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia H. J. McClafferty M.D. for: J. R. Davis, M.D. July 24 49

DUE TO

(B) General arteriosclerosis — 3 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Psychosis with arteriosclerosis, fracture right hip — 2 years 7 months

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

OFFICE OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Institution
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Seton Institute 6420 Reistertown Road 28/1
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-19-49 (?) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR?: Slipped + fell to floor

22. I hereby certify that I attended the deceased from Dec. 19 48 to July 26, 19 49 that I last saw the deceased alive on July 26, 19 49 and that death occurred at 2 12 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Walter O. Salvers M.D.
23B. ADDRESS: 6420 Reistertown Rd
23C. DATE SIGNED: 7-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/29/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cem.
24D. LOCATION (City, town, or county) (State): Balto/, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICHNER & SONS ADDRESS: Balto., Md.

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G76631 G76631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT GRANT VANSANT

2. DATE OF DEATH July 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Edgewood Nursing Home 6000 Bellona Ave.

C. Length of stay in Baltimore — Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 716 Richwood Ave. 27-10

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH Sept. 25, 1868
9. AGE (In years last birthday) 80 yrs. If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Blower (Rtd)
10B. KIND OF BUSINESS OR INDUSTRY Glass
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME August Vansant
14. MOTHER'S MAIDEN NAME Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mr. Carroll L. Vansant ADDRESS 716 Richwood Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH:
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis. — 4 days
DUE TO
(B) arteriosclerosis — 2 years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1938 *to* July 26, 1949 *that I last saw the deceased alive on* July 25, 19 49 *and that death occurred at* 1:30 a *m., from the causes and on the date stated above.*

23A. SIGNATURE Robert L. Mortimer Jr M. D.
23B. ADDRESS 2706 St Paul St
23C. DATE SIGNED 7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/29/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
24D. LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 27 1949
REGISTRAR'S SIGNATURE Transcription from Baltimore, Md.
25. FUNERAL DIRECTOR WM. J. TICKNER & SONS
ADDRESS Balto., Md.

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G76632

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76632

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE GUY MICHAEL

2. DATE OF DEATH: July 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2323 Harford Rd.

c. Length of stay in Baltimore: 30 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2323 Harford Rd.

8-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widowed	Apr. 7, 1865	84 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Smithtown, W. Va.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Lucian Michael

14. MOTHER'S MAIDEN NAME: Isabelle Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Isabelle M. Whitmore ADDRESS: 2323 Harford Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial insufficiency.

DUE TO

(B) Arteriosclerosis, &

DUE TO

(C) Myocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A), STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1 49 *to* July 27 49, *that I last saw the deceased alive on* July 26, 1949, *and that death occurred at* 5:15 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Peter E. Schenuch M. D.

23B. ADDRESS: 1337 S. Charles St

23C. DATE SIGNED: 7/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 7/27/49

24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.

24D. LOCATION (City, town, or county) (State): Fairmount, W. Va.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

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G76633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76633 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) STANISLAW MARKOWISKI MARKOWSKI MARKOWSKI

2. DATE OF DEATH July 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore 4 5 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 652 Portland St.

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH 4/23/1879

9. AGE (In years last birthday) 70 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coat Maker.

10B. KIND OF BUSINESS OR INDUSTRY TAILORING

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Regina Polacik ADDRESS 1740 Bank St

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-Sclerosis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L. Rogers M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 24 Jul 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/27/49

24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary

24D. LOCATION (City, town, or county) Maryland Park (State)

ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR JUL 27 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Charles W. Cochran

97 To Me Dept

151

G76634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76634 Registered No.

BIRTH NO. B.C. 49-04623

1. NAME OF DECEASED (Type or Print) Patricia Ann (Robinson) Robertson

2. DATE OF DEATH 26 July 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1421 Olive St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md
D. STREET ADDRESS (If rural, give location) 1421 Olive St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) (DOA) South Baltimore General Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Infant	March 3, 1949		4	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant		Maryland	

13. FATHER'S NAME William A. Robertson

14. MOTHER'S MAIDEN NAME Helen F. Stone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Helen F. Robertson	1421 Olive St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hydrocephalus
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congenital Dislocation, Hips, Bilateral

INTERVAL BETWEEN ONSET AND DEATH: 5 mos.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Wm. H. Kammer, Jr. M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED 26 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 28 1949

24C. NAME OF CEMETERY OR CREMATORY Leda Lee

24D. LOCATION (City, town, or county) (State) C. A. Co

DATE RECEIVED BY LOCAL REGISTRAR JUL 27 1949

REGISTRAR'S SIGNATURE Mailed from Williamsport, Md

25. FUNERAL DIRECTOR & Howard Evans

ADDRESS 1400 S. Gilmor St

157a

G76635

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76635

Registered No.

1. NAME OF DECEASED (Type or Print): William Turner.

2. DATE OF DEATH: July 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 13 19 Madison Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon-Wil-Da Nursing Home 1317 Madison Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 18 b. Stockton St.
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 18 - 3
D. STREET ADDRESS (If rural, give location) 18 b. Stockton St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	C	married	January 1, 1881	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Porter		Md.	U.S.A.

13. FATHER'S NAME: Thomas Turner.

14. MOTHER'S MAIDEN NAME: Rachel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Eva Turner.	18 b. Stockton St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Apoplexy, Cardio Renal — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Disease Hypertension 6 mos.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5/15, 19 49, *to* 7/23, 19 49, *that I last saw the deceased alive on* 7/23, 19 49, *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. E. Jackson M. D.	600 Washington Ave	7/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-28-1949	W. Calvary	Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 27 1949	Henrietta Lee Williams, M.D.	Mrs Katie R. Williams	3321

VS 150

131a

BIRTH NO. G76636

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 13 G76636

1. NAME OF DECEASED (Type or Print): Thomas Hall McGowans.

2. DATE OF DEATH: July 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 710 Brune St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 710 Brune St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 710 Brune St.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 710 Brune St. 17-23

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	C	married	Nov. 20, 1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Porter		A. A County, Md.	U. S. A.

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME Asja

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No.		

17. INFORMANT: Carleaner McGowans ADDRESS 710 Brune St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertension Coronia Disease — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B)
DUE TO,
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-10, 1949 *to* 7-25, 19 49 *that I last saw the deceased alive on* 7-25, 1949, *and that death occurred at* 7 p *m., from the cause and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles J. Wadell M. D.	861 Hanlon	7/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-28-49	Mt. Auburn Cem	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 27 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR: Mrs. Hattie R. Williams ADDRESS 3224 Edmondson Ave

937

VS 150

CERTIFICATE CORRECTED 11-22-49

G76637 BALTIMORE CITY HEALTH DEPARTMENT G76637

BIRTH NO. Charles Theodore

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) ~~(JAMES)~~ MORRISON, Jr. N-813-7

2. DATE OF DEATH July 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Balto. City Hosp.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sparrows Point
D. STREET ADDRESS (If rural, give location) 206 "E" Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	Nov. -19-1929	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Tin Mill - Bath Steel	Balto., Md.	

13. FATHER'S NAME Charles Morrison Sr.

14. MOTHER'S MAIDEN NAME Margaret Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mr. Charles Morrison (Father)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of skull
DUE TO Sub dural hematoma, bilateral
ANTECEDENT CAUSES
(B) contusion, brain
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO CONTUSION
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Lodge Farm Rd., 2000' west of North Point Road

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 24, 1949 Approx. 10P. M.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Auto. overturned (deceased--driver)

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED July 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-25-49	Sacred Heart	Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR — ADDRESS John B. Connelly - 418 Eastern Ave

JUL 27 1949

170c

Balto 21, Md.

G76638 BALTIMORE CITY HEALTH DEPARTMENT G76638

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MILLARD LASHLEY

2. DATE OF DEATH July 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS. (If rural, give location) 1520 E. Biddle St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	C	Married	July 4 1913	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Lowen Lashley
14. MOTHER'S MAIDEN NAME Mollie Edmonds
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Florence Lashley ADDRESS 1520 E Biddle St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Dilatation of Heart
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE William J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED July 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal
24B. DATE July 27/49
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State) La Grange Va

DATE RECEIVED BY LOCAL REGISTRAR JUL 27 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm. Robert Gelling & Daughter
ADDRESS 1129 N. Caroline St

95c

G76639 BALTIMORE CITY HEALTH DEPARTMENT G76639

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mary Hawkins | 2. DATE OF DEATH: 7-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1314 Slater Road
C. Length of stay in Baltimore: 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland | B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1314 Slater Road.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Negro	Single	1-12-1864	85 yrs.	6	13	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work.		Charles County, Md	U.S.

13. FATHER'S NAME: Robert Francis Hawkins
14. MOTHER'S MAIDEN NAME: Mary Louise DAY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Robert Francis Hawkins, Sr	Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia
DUE TO
(B) Senility
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 24 hours.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO. ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-3, 1949, *to* July 25, 1949, *that I last saw the deceased alive on* July 25th 1949, *and that death occurred at* 1:15 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jerry L. Luck M. D.	303 Bridgeview Road	July 25 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	July 27th 1949	New Cathedral Cem	Frederick Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 27 1949		Mr. Robert A. Ellis & Sons	1629 B 1129 N. Carlton St.

VS 150

G76640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148

G76640

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Sylvia Lucas

2. DATE OF DEATH July 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1608 N. Dallas St

C. Length of stay in Baltimore 15 yrs. (Yrs., Mos., Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1608 N. Dallas St 8-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	C.	Widow	Feb. 22, 1908	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laundress		Orangeburg S.C.	

13. FATHER'S NAME Abel Salley

14. MOTHER'S MAIDEN NAME Adelaide Epps

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Jones Salley	1608 N. Dallas St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CANCER OF THROAT — Abt 18 Mo

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from May 27, 1949, to July 24, 1949, that I last saw the deceased alive on 7-22-, 1949 and that death occurred at 9:20 a. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Maurice Adams M. D.	238 N. Carey St	7-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	July 27/49		Orangeburg S. C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
27 1949	Temperance Williams, M.D.	Mrs. Robert A. Elliott Daughter	1129 N. Caroline St.

VS 150

45F

76641 BC-49-14869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76641

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Baby Girl Snyder

2. DATE OF DEATH 7-22-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

c. Length of stay in Baltimore 4 hrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE. (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 721 W. Lexington St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	W	—	7-22-49				4	10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Snyder

14. MOTHER'S MAIDEN NAME Theresa Yeadel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Father ADDRESS Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) asphyxia

DUE TO

(B) Prematurity

DUE TO

(C) Premature separation of placenta

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 hrs 10 min

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* July 22, 1949, *to* July 22, 1949, *that I last saw the deceased alive on* July 22, 1949, *and that death occurred at* 6:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Walter K. Schulze M. D.

23B. ADDRESS Franklin Sq. Hosp.

23C. DATE SIGNED 7/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State) JUL 26 1949

DATE RECEIVED BY LOCAL REGISTRAR JUL 27 1949

REGISTRAR'S SIGNATURE WITHOUT MEDICAL CERTIFICATE

25. FUNERAL DIRECTOR Commissioner of Health ADDRESS

VS 150

160c

G76642

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 143

G76642

Registered No.

1. NAME OF DECEASED (Type or Print) Garfield Reed

2. DATE OF DEATH July 24- 1949

3. PLACE OF DEATH
A. Baltimore City Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 715 Franklin St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-3

D. STREET ADDRESS (If rural, give location) 715 Franklin Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Col	W	7/23/1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	—	Middleburg Va	U.S.

13. FATHER'S NAME Frank Reed

14. MOTHER'S MAIDEN NAME Hester Coates

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Roville Reed	104 Bruce St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension

DUE TO Arteriosclerosis

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-1 *,* 1949 *to* 7-21 *,* 1949 *that I last saw the deceased alive on* 7-23- 1949 *and that death occurred at* 9:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
H. Bradley	Reisterstown Md	7-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 28th	Shiloh Cemetery	Middleburg Va

DATE RECEIVED BY LOCAL REGISTRAR JUL 27 1949

REGISTRAR'S SIGNATURE Registrar for Baltimore, Md

25. FUNERAL DIRECTOR Joseph L Russ ADDRESS 1206 McCulloh St. 937

VS 150

G76643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50.1 G76643

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print) **Mr. Ernest Clayton Hash**

2. DATE OF DEATH **July 27, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **St. Joseph's Hospital**

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY Harford
C. CITY OR TOWN **Fallston** (If outside corporate limits, write RURAL and give township) **(Rural)**
D. STREET ADDRESS (If rural, give location) —

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	May 22 1913	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Farmhand - I.M. Smith**
10B. KIND OF BUSINESS OR INDUSTRY **FARM HAND**
11. BIRTHPLACE (State or foreign country) **Virginia - MOUTH OF WILSON**
12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **FELIX NEAL HASH**
14. MOTHER'S MAIDEN NAME **BEATRICE HALSEY**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **UNKNOWN** (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. **190-12-7100**
17. INFORMANT **MRS WAVE HASH** ADDRESS **FALLSTON MD**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Generalized peritonitis** — INTERVAL BETWEEN ONSET AND DEATH
DUE TO **perforated gangrenous**
(B) **Ruptured Appendix**
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/24/49	Ruptured Appendix	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/23/ , 19 49 *to* 7/27/ , 19 49 , *that I last saw the deceased alive on* 7/27/ , 19 49 , *and that death occurred at* 7:25 AM., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William F. Reaver M. D.	1400 N. Caroline Street	7/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	July 28/49	Young's Chapel	Mouth of Wilson Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 27 1949	Carrington Williams, M.D.	Walter A. Archer	Bowers, Md.

121

G76644

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54-0

G76644

Registered No.

1. NAME OF DECEASED (Type or Print) John Henry Bartman

2. DATE OF DEATH 7/26/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 530 S. Ellwood Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 530 S. Ellwood Avenue

C. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore , Md
D. STREET ADDRESS (If rural, give location) 530 S. Ellwood Avenue

1-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Marride	1/21/86	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinest		Baltimore	USA

13. FATHER'S NAME: Christopher Bartman

14. MOTHER'S MAIDEN NAME: Lpuies Bremmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT- Mary Bartman ADDRESS 530 S. Ellwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensplic Cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chr. myocarditis — about 3 years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 14, 1948 *to* July 26, 1949 *that I last saw the deceased alive on* July 25, 1949, *and that death occurred at* 8.40 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
G. M. Bacon, M. D.	2810 Taylor Ave.	6/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Burial	7/30/49	Oak Lawn	Baltimore , Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
7-28-49	Huntington Williams, M.D.	Lilly & Zeiler , 403 S. Wolfe Stree

VS 150

124B

G76645

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76645

Registered No.

1. NAME OF DECEASED (Type or Print) Mrs Sophie Scherr

2. DATE OF DEATH 7-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Greenspring & Belvedere Levindale Home
c. Length of stay in Baltimore 55 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-12
D. STREET ADDRESS (If rural, give location) 3806 Park Heights Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	White	Widow	1881	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Russia	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? Alberts	Rena ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Minnie Prock	3806 ParkHeights Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral Arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertension, Diabetes.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-22, 1949, *to* 7-28, 1949, *that I last saw the deceased alive on* 7-28, 1949, *and that death occurred at* 4:15 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jerome J. Blumberg M. D.		7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 29, 1949	Hebrew Herring Run Cem	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 28 1949	Hunter Jones Williams, M.D.	S. Levinson & Bros.	1124-26 N. North Avenue

VS 150

61

G76646

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76646

1. NAME OF DECEASED (Type or Print): Ada Kalvansky

2. DATE OF DEATH: July 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2817 Parkwood Ave
C. Length of stay in Baltimore: 42 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-4
D. STREET ADDRESS (If rural, give location): 2817 Parkwood Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Russia	

13. FATHER'S NAME: Meyer Brill

14. MOTHER'S MAIDEN NAME: Gertrude Torf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Ida Miller	Parkwood Ave 2817

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lymphosarcoma - primary right orbit - Generalized metastasis

DUE TO

(B) CARDIO - RESPIRATORY FAILURE

DUE TO

(C) TERMINAL BRONCHOPNEUMONIA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/26/45 19__, *to* July 27, 1949 *that I last saw the deceased alive on* July 27, 1949, *and that death occurred at* 11:55 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Willard Applegarth M. D.	2511 Reisterstown Rd	7/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24C. LOCATION (City, town, or county) (State)
Burial	July 28, 1949	Hebrew Herring Run Cem	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 28 1949	Thurlington Williams, M.D.	Sol Levinson & Bros	1126 W North Ave

VS 150

55B

G76647

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43

Registered No. G76647

1. NAME OF DECEASED (Type or Print)	ARCHIP SWEREDENKOV
2. DATE OF DEATH	July 26, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	South Baltimore General Hosp.
c. Length of stay in Baltimore (Yrs. Mos. Days)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	1152 Hull Street 24-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White			61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Russia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? Swerdenkov	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Anthony K. Uchnuk	3411 N Milton

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)	(A) Hypertensive cardiovascular disease	
	DUE TO	
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
William J. McClafferty M.D.		7-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 29 49	Holy Trinity Russian	Edgewood Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 28 1949	Huntington Williams M.D.	John A. Boekhaus for J.	1905 E. Pratt

VS 151

93

G76648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17

Registered No. G76648

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen Lange

2. DATE OF DEATH: July 27 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland (Halsted)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 426 Evesham Ave

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 1-3-87
9. AGE (In years last birthday): 62
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Lange
14. MOTHER'S MAIDEN NAME: Anna Reis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Breast
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 1948
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Breast
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/20 *to* 7/27, 1949, *that I last saw the deceased alive on* 7/27, 1949, *and that death occurred at* 2:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Thomas N. Johns M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 7-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 30/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Henry H. Jenkins Sons Co
ADDRESS: 4905 York Rd

VS 150

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G76649

J L - 130584

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

63

G76649

Registered No.

1. NAME OF DECEASED (Type or Print) Harry Schwartz

2. DATE OF DEATH July 27, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 43 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-3
D. STREET ADDRESS (If rural, give location) 2130 E. Baltimore St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	White	Married	? ? ?	65 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor	Self	Russia	

13. FATHER'S NAME: Samuel Schwartz

14. MOTHER'S MAIDEN NAME: Lee ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		B. C. H. Records,	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of the Lung	3 mos.
DUE TO		
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Cerebral Vascular Accident	2 yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* July 26, 1949 *to* July 27, 1949, *that I last saw the deceased alive on* July 27, 1949, *and that death occurred at* 9.10 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. S. Rogers, M. D.	4940 Eastern Ave.	July 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-28-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 28 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

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G76630

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 G76630 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Catherine Rizulok.

2. DATE OF DEATH July 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 707 S Bethel
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) John Hopkins Hospital
C. Length of stay in Baltimore 67 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2-3
D. STREET ADDRESS (If rural, give location) 707 S Bethel St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married		67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10B. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME Simon Andrenka
14. MOTHER'S MAIDEN NAME Elizabeth Burian
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT John Rizulok ADDRESS 707 S Bethel

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Hypertension Cardio-Vascular disease	
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE William J. Helfrich M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED July 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-30-49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 28 1949
REGISTRAR'S SIGNATURE Tunstall Williams, M.D.
25. FUNERAL DIRECTOR Frank Novak & Son ADDRESS 900 Chester

93D

DR. BOOK - 18-E. EAGER -

G76651

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76651

1. NAME OF DECEASED (Type or Print) Emma Justine Humes

2. DATE OF DEATH July 27-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 416 N. Broadway

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 416 N. BROADWAY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO MD.
D. STREET ADDRESS (If rural, give location) 416 N. BROADWAY 6-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	WIDOW	OCT-23-1868	80	9	4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
AT HOME		BALTIMORE MD.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
LOUIS WEUST HOFF	EMMA BINDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			NORMA I-HOMES	416-N-Broadway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Arteriosclerosis

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 15, 1949, *to* July 26, 1949, *that I last saw the deceased alive on* July 26, 1949 *and that death occurred at* 4 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter B. Buck M. D.	18 E Eager St Balto-2	July 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-29-49	LOUDON PARK	BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 28 1949	Huntington Williams, M.D.	Ellsworth Armacost	5119 Liberty Heights Ave.

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~~76652~~ ✓76652 G76652

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Hall, Jr.

2. DATE OF DEATH: 7/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 619 Archer St.
C. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 619 Archer St. 21-2

5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Aug. 23, 1901
9. AGE (In years last birthday): 47 48
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Hall Sr.
14. MOTHER'S MAIDEN NAME: Mary Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): World War I
16. SOCIAL SECURITY NO.: 218-10-3174

17. INFORMANT: [illegible] ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Encephalitis pyogenic — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Abscessed teeth — 1 months
DUE TO
(C) Pyorrhea alveolaris — 1 year

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1949 *to* July 26, 1949, *that I last saw the deceased alive on* July 25, 1949, *and that death occurred at* 4:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: John P. Ulrich, Jr. M. D.
23B. ADDRESS: 1227 Wash. Blv'd
23C. DATE SIGNED: 7-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/29/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph L. Rees, 1200 McCulloh St. ADDRESS

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G76653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

60 ✓

G76653

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MR. George Ora Trimble

2. DATE OF DEATH 7/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Bon Secours Hosp.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 23
D. STREET ADDRESS (If rural, give location) 2226 Penrose Ave 20-2

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	married	12/5/1893	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired Policeman	Police Dept., City	Olney Ill.	U.S.

13. FATHER'S NAME
Isaac Trimble

14. MOTHER'S MAIDEN NAME
-

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Son	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia
DUE TO Stone in Rt. Kidney
(B) Pyelonephritis and hydro. gathering under (Rt.)
DUE TO Cystitis
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Urinary fistula

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/25, 1949 *to* 7/27, 1949, *that I last saw the deceased alive on* 7/27, 1949, *and that death occurred at* 10:05 A.M. *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William S. Womack M. D.	Bon Secours Hosp.	7/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/30/49	Woodlawn Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 28 1949	Curtis Lee Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS-190

134a

G76654

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

124 G76654 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRIETT WATERS

2. DATE OF DEATH: 7/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 908 N. DALLAS ST
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 15 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 7-4
D. STREET ADDRESS (If rural, give location): 908 N. DALLAS ST.

5. SEX: F
6. COLOR OR RACE: C.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: Nov. 23, 1905
9. AGE (In years last birthday): 43 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House WIFE
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: BUCK INGRAM
14. MOTHER'S MAIDEN NAME: SALLIE WILKINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: HERBERT WATERS ADDRESS: 908 N. Dallas

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uterine Hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Carcinoma of uterus & genital Pelvic Metastasis — 8 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* June 5, 1949 *to* July 25, 1949 *that I last saw the deceased alive on* July 25, 1949, *and that death occurred at* 10:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ralph H. Young M. D.
23B. ADDRESS: 1429 E. Monument St
23C. DATE SIGNED: 7/27/49 (State)

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/28/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county): B. C. County, Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Joseph B. Lockwood ADDRESS: 1304 N. Central Ave

VS 150

48B

G76655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

334 G76655

Registered No.

BIRTH NO.

CH OLCHOWSKI

1. NAME OF DECEASED (Type or Print) Catherine Olchowska

2. DATE OF DEATH July 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Little Sisters of the Poor Home for the Aged

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 10-1
D. STREET ADDRESS (If rural, give location) 1200 Valley St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If over 1 year last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W	W	about 1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
—	—

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Lisby Sysdonis ADDRESS 1205 Valley St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Arterio Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: + yrs

DUE TO

(B) General Arterio Sclerosis — 5 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 15, 1949 *to* 26 July, 1949 *that I last saw the deceased alive on* July 24, 1949 *and that death occurred at* 6:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. Gill Hall M. D.	1631 E North Av	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-29-49	Holy Rosary	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 28 1949	Huntington Williams, M.D.	George R. Weber	705 S. Conkling St

VS 150

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G76656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

26 D

G76656

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Sarah McCorkle

2. DATE OF DEATH 7-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-3
D. STREET ADDRESS (If rural, give location) 2261 Madison Ave

5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH Oct. 27, 1873
9. AGE (In years last birthday) 75
If Under 1 Year: Months — Days
If Under 24 Hours: Hours — Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Lincoln Co. N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Gattie
14. MOTHER'S MAIDEN NAME Angeline Monday

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Lillah Williams ADDRESS 2261 Madison Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Diabetic Acidosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-23-1949 *to* 7-25-1949, *that I last saw the deceased alive on* 7-25-1949, *and that death occurred at* 1:55 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE A. E. Bradley Jr. M. D.
23B. ADDRESS 2 Broadway
23C. DATE SIGNED 7-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/27/1949
24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.
24D. LOCATION (City, Town, or county) (State) Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR Holland Funeral Home
ADDRESS 1631 Druid Hill Ave

VS 150

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Dod 1/24 Out Patient

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

491 Registered No. G76657

BIRTH NO. 76657 B.C.H. 9252

1. NAME OF DECEASED (Type or Print): Jeanette Levi

2. DATE OF DEATH: July 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 172 N. Out Pat

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-2
D. STREET ADDRESS (If rural, give location): 107 N. Gilmore St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored		10-24-47.	1	9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Balto Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ralph Levi

14. MOTHER'S MAIDEN NAME: Dorothy Kesler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure
DUE TO Lobular pneumonia mp

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
John R. Davis, M.D.
per William J. McCafferty M.D.
CHIEF OR ASST. MEDICAL EXAMINER

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____ 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE Barton Childs M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED 26 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE 7-28-49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 28 1949

REGISTRAR'S SIGNATURE: Temporary Washington Williams Clerk

25. FUNERAL DIRECTOR: Mrs Katie Priddy Williams & Sons

ADDRESS 322 Edmondson

Released to Hospital

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G76658

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43

Registered No. G76658

1. NAME OF DECEASED (Type or Print): Ely Taylor

2. DATE OF DEATH: July 24-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland. Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1036 N. Durham St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 7-4

c. Length of stay in Baltimore: 40 yrs. (Yrs. / Mos. / Days)

D. STREET ADDRESS (If rural, give location): 1036 N. Durham St

5. SEX: Male

6. COLOR OR RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: June 1-1886

9. AGE (In years last birthday) (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.): 63

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Northumberland Co. Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Taylor

14. MOTHER'S MAIDEN NAME: Hannah Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Edna Taylor ADDRESS: 1036 N. Durham St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Hypertensive Cardio Vascular Disease

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: (A) 7 days; (B) ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 22 1949, to July 24 1949 *that I last saw the deceased alive on* July 24 1949, *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: T. K. Adams M. D.

23B. ADDRESS: 1222 N. Caroline

23C. DATE SIGNED: 7-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: July 28-49

24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem.

24D. LOCATION (City, Town, or County) (State): Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Chas D. Wilson ADDRESS: 1005 Bentley Ave

VS 150

93D

76659

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 63 G76659

1. NAME OF DECEASED (Type or Print): Ada Foster

2. DATE OF DEATH: July 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1702 Lewellyn
C. Length of stay in Baltimore: 12 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1702 Lewellyn 8-7

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 2. 1917
9. AGE (In years last birthday): 31 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Cumberland Co. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ernest Buntly
14. MOTHER'S MAIDEN NAME: Hattie Mayo
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James P. Foster ADDRESS: 1702 Llewelyn Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Pulmonary Edema
DUE TO Syphilitic Aortitis
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: William J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: July 26, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 28 49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1000 Brantly Ave.

VS 151

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G76660 — BALTIMORE CITY HEALTH DEPARTMENT — G76660

BIRTH NO. G76660

CERTIFICATE OF DEATH

Registered No. 17-4

1. NAME OF DECEASED (Type or Print): Clara B. King

2. DATE OF DEATH: July 27 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Bellona Av.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Edgewood San.
c. Length of stay in Baltimore Yrs. 1 Mos. Wks. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
A. STATE Md.
B. COUNTY Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2609 Guilford 12-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last Birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Sep 1 1876	72 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	none	Maryland	U.S.

13. FATHER'S NAME: Walter L. Olson

14. MOTHER'S MAIDEN NAME: Maria L. Fowler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	None	Wm. L. Cook King (son)	2609 Guilford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of uterus — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	No	No

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

I hereby certify that I attended the deceased from July 16, 1949 to July 27, 1949 that I last saw the deceased alive on July 25, 1949, and that death occurred at 10 A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
O H L Jones M.D.	2818 St. Paul St	July 27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	July 29-49	Loudon Park	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 28 1949

REGISTRAR'S SIGNATURE: Lexington Williams, M.D.

25. FUNERAL DIRECTOR: Stuart Morris — ADDRESS: Balto.

VS 150

48 B

G76661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X E 9 7 4.6 G76661 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD JOHN / LINJER

N-991.

2. DATE OF DEATH July 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Mercy Hospital
c. Length of stay in Baltimore Unknown. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Wisconsin
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Madison (Capital Annex)
D. STREET ADDRESS (If rural, give location)

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan. 18, 1900
9. AGE (In years last birthday): 49 sml
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): doctor-denist
10B. KIND OF BUSINESS OR INDUSTRY: Dentistry
11. BIRTHPLACE (State or foreign country): Minneapolis, Minn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes (If yes, give war or dates of service) Both World Wars
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Veterans Administration, ADDRESS Balto., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation
DUE TO
(B) Hanging

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) hotel
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Emerson Hotel, Calvert & Baltimore Sts.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 7, 1949, 9.00 P. m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Hanged self from shower curtain rod by rope

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE Carl L. Rogers M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED July 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 28, 1949
24C. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cemetery
24D. LOCATION (City, town, or county) (State) Balto., Maryland

DATE RECEIVED BY LOCAL REGISTRAR JUL 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co., 108 W. North Ave. Baltimore #1, Maryland

164a

VS 151

G76662

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

11 G76662 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARTHA PIERCE

2. DATE OF DEATH July 27, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTO. GEN. HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE #21 Essex
D. STREET ADDRESS (If rural, give location) 1413 EASTERN AVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	SEPARATED	3/14/07	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H'WIFE
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Mark Hecker
14. MOTHER'S MAIDEN NAME Rose Lawrence

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Marie Hullett ADDRESS

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HYDRONEPHROSIS - BILATERAL

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CARCINOMA OF CERVIX

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 8 1949 *to* July 27 1949, *that I last saw the deceased alive on* July 27 1949, *and that death occurred at* 5 45 AM *from the causes and on the date stated above.*

23A. SIGNATURE William B. Cooper M.D.
23B. ADDRESS 1213 Light St.
23C. DATE SIGNED 7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/30/49
24C. NAME OF CEMETERY OR CREMATORY Cedar Hill
24D. LOCATION (City, town, or county) (State) AA County Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 28 1949
REGISTRAR'S SIGNATURE Williams, M.D.
25. FUNERAL DIRECTOR J. J. Brzezinski ADDRESS 1407 Eastern Ave

48a

G76663

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76663 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) REBECCA WILKINS

2. DATE OF DEATH JULY 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL

C. Length of stay in Baltimore 1½ Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Worcester
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BERLIN
D. STREET ADDRESS (If rural, give location) BERLIN, 209

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W.	SINGLE	Sept. 10, 1949	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT
10B. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) MARY LAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ERNEST WILKINS
14. MOTHER'S MAIDEN NAME ELLA MITCHELL
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT FATHER ADDRESS SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE, OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) PNEUMONITIS	1 MONTH
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JUNE 28, 1949 to July 27, 1949 *that I last saw the deceased alive on* July 27, 1949, *and that death occurred at* 6:25 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE Edmund B. Middleton M. D.
23B. ADDRESS University Hospital
23C. DATE SIGNED July 27, 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 31, 1949
24C. NAME OF CEMETERY OR CREMATORY New Hope
24D. LOCATION (City, town, or county) (State) Hyattsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR M. Parks Watson ADDRESS Silbyville Del.

109

G76664

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76664

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth Grap

2. DATE OF DEATH July 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-3

D. STREET ADDRESS (If rural, give location) 915 Lemmon Street

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Oct. 23, 1892

9. AGE (In years last birthday) 56

If Under 1 Year: Months Days

If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Colvin

14. MOTHER'S MAIDEN NAME Mary Wheatley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Patient ADDRESS Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Abdominal Wall Abscess + Diabetes Mellitus — 3 wks. ?

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION July 22, 1949

19B. MAJOR FINDINGS OF OPERATION Abdominal Wall Abscess

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? /

22. *I hereby certify that I attended the deceased from* July 22, 1949 *to* July 27, 1949 *that I last saw the deceased alive on* July 27, 1949 *and that death occurred at* 9:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE John S. Reynolds M. D.

23B. ADDRESS Mercy Hosp.

23C. DATE SIGNED July 27 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/30/49

24C. NAME OF CEMETERY OR CREMATORY Mt Olivet Cem.

24D. LOCATION (City, town, or county) (State) 2930 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR JUL 28 1949

REGISTRAR'S SIGNATURE Cuntrington Williams, M.D.

25. FUNERAL DIRECTOR John J. Cowan & Son

ADDRESS 1900 Wolfe St.

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BIRTH NO.

M.F ✓ E902.7 Xrae

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76665
Registered No.

1. NAME OF DECEASED (Type or Print) Howard B. Dowell

N-817

2. DATE OF DEATH July 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3605 Hillsdale Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Anderson Nursing Home

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-15
D. STREET ADDRESS (If rural, give location) 5015 Falls Road Terrace

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	March 3, 1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George E. Dowell

14. MOTHER'S MAIDEN NAME Emma Nalls

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Mr. Geo. H. Dowell 5015 Falls Rd. Terrace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH 2 yrs

DUE TO

(B) Arteriosclerosis — 4 yrs

DUE TO

(C) Fract. left humerus July 8-49 Shock.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
William J. McCafferty M.D.
(CORONER ASST. MEDICAL EXAMINER)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) accident

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) nursing home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) and Rest Home 3605 Hillsdale Rd. Anderson Convalescent

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 8, 1949 ? m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Fell to the floor getting out of bed 28-01

22. *I hereby certify that I attended the deceased from* 1-1- , 1922 *to* 7-26 , 1949, *that I last saw the deceased alive on* 7-26 , 1949, *and that death occurred at* 6. P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Howard B. Warner M.D.

23B. ADDRESS 2604 Garrison Blvd

23C. DATE SIGNED 7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
cremation	July 28, 1949	Loudon Park Cemetery	Fred. Ave. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 28 1949

REGISTRAR'S SIGNATURE Carrington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS John O. Mitchell Sons Inc. 1900 Eutaw Place

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G76666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76666 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Francis Smith

2. DATE OF DEATH JUL 27 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Delair
D. STREET ADDRESS (If rural, give location) 306 Main St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore 0 Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	11-1-1888	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor		Va	

13. FATHER'S NAME Walter Smith

14. MOTHER'S MAIDEN NAME Lillie Stiglemen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure following

DUE TO

(B) Operation for carcinoma of tongue

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION July 26, 1949

19B. MAJOR FINDINGS OF OPERATION Carcinoma of Tongue

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-24 1949 *to* 7-27 1949, *that I last saw the deceased alive on* 7-27 1949 *and that death occurred at* 3:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Thomas N P Johns M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED July 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 29/49

24C. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Cem

24D. LOCATION (City, town, or county) (State) Bel Air Md

25. FUNERAL DIRECTOR ADDRESS John D. Mitchell Home

DATE RECEIVED BY LOCAL REGISTRAR JUL 28 1949

REGISTRAR'S SIGNATURE Tunstall Williams, M.D.

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G76667

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76667
Registered No.

1. NAME OF DECEASED (Type or Print): Robert James Young

2. DATE OF DEATH: 7-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: University Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2703
D. STREET ADDRESS (If rural, give location): 2514 Hermosa ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	M	April 2-1913	36				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self employed

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Oliver J. Young

14. MOTHER'S MAIDEN NAME: Estella Wilfide

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. W J Young ADDRESS: 2514 Hermosa Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 12 days?

DUE TO

ANTECEDENT CAUSES

(B) Post op prostatectomy

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 7-15-49

19B. MAJOR FINDINGS OF OPERATION: Bronchial adenoma (right)

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from 7-10, 19 49 to 7-27, 19 49 that I last saw the deceased alive on [illegible], 19 49 and that death occurred at 11 A m., from the causes and on the date stated above.

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: Univ. Hosp

23C. DATE SIGNED: 7-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 7-30-49

24C. NAME OF CEMETERY OR CREMATORY: Western

24D. LOCATION (City, town, or county) (State): Edmondson Ave Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR:

REGISTRAR'S SIGNATURE: Certified for Milleanna, M.D.

25. FUNERAL DIRECTOR: John D Mitchell & Son ADDRESS: 1900 Eutaw Pl

56E

VS 150

G76668

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76668

Registered No.

1. NAME OF DECEASED (Type or Print) Conrad Kiersching

2. DATE OF DEATH July 27/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Va.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Staunton
D. STREET ADDRESS (If rural, give location) Kalorama Cottage

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Child

8. DATE OF BIRTH 4-30-49

9. AGE (In years last birthday) — If Under 1 Year: Months 3, Days 27 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Kiersching

14. MOTHER'S MAIDEN NAME Adele Mrouch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Hydrocephalus	4 mos.
DUE TO		P.O. cardiac failure	6 hrs.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO		
	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-19, 1949 *to* 7-27, 1949 *that I last saw the deceased alive on* 7-27, 1949, *and that death occurred at* 9 25 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Wm H. Taussig M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED 7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7-30-49

24C. NAME OF CEMETERY OR CREMATORY STAUNTON

24D. LOCATION (City, town, or county) (State) VA.

DATE RECEIVED BY LOCAL REGISTRAR JUL 28 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John T. Mitchell & Sons

ADDRESS 157a / 900 Eutaw Pl.

VS 150

G76669

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1 G76669 Registered No.

1. NAME OF DECEASED (Type or Print): Florina Marguerite

2. DATE OF DEATH: July 27, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland 2208 Edley
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2208 Edley St
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 2208 Edley St 25-33

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Female	White	Widow	Nov 12, 1861	88				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Calvert Co Md	

13. FATHER'S NAME: John King

14. MOTHER'S MAIDEN NAME: Margaret Hooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		none		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Coronary occlusion
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
William S Telford M.D.		July 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county)	(State)
Burial	7/30/49	Emmanuel	Emmanuel Calvert Co	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 28 1949	Huntington Williams, M.D.	Wilson Co Inc	1217 E Baltimore St

VS 151

94a

G76670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76670

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Leonard George Purcell

2. DATE OF DEATH: 7/22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 15-3

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. General Hospital

D. STREET ADDRESS (If rural, give location): 1732 N Pulaski St

c. Length of stay in Baltimore: 30 yrs. (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	married	Dec. 18, 1890	58 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shipping Clerk	lumber	St. Mary's Co., Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George W. Purcell	Ruth Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	215-05-3575	Mrs. Mary A. Purcell	1732 N. Pulaski St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease — DUE TO

ANTECEDENT CAUSES

(B) — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: P. J. Sulewski M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED: 7/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/30/49	Moreland Mem. Pk.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 28 1949	Huntington Williams, MD	WM. J. TICKNER & SONS	Balto., Md.

VS 151

94a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G76671

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76671 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jason Healey

2. DATE OF DEATH July 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 808 Pennsylvania Ave. 17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C			50 ?				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic cardiovascular disease	
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
II	(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR
23C. DATE SIGNED July 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	7/30/49	Mt Calvary	A.A. County, Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS A. Halstead - 918 Druid Hill Ave 937

VS 151

G76672 BIRTH NO. B.C. H-75951

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

7546 Registered No. G76672

1. NAME OF DECEASED (Type or Print): John Gouker
2. DATE OF DEATH: July 27 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Hal 3
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Long Green
D. STREET ADDRESS (If rural, give location): —

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Child	4-7-47	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: John Gouker
14. MOTHER'S MAIDEN NAME: Gladys Austin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
			JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital anomaly of pulmonary veins
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: July 27, 1949
19B. MAJOR FINDINGS OF OPERATION: Congenital anomaly of pulmonary veins
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-21-, 1949 *to* 7-27-, 1949 *that I last saw the deceased alive on* 7-27, 19— *, and that death occurred at* 2 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard L. Tuttle Jr. M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 7-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 29-49
24C. NAME OF CEMETERY OR CREMATORY: Pikesville
24D. LOCATION (City, town, or county) (State): Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Clarence E. Arthur
ADDRESS: Fork Md.

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G76673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59.0

Registered No. G76673

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rollin Marc Wahl

2. DATE OF DEATH July 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Calvert
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Prince Frederick
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Child	5-18-49		2½	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME Walter Wahl

14. MOTHER'S MAIDEN NAME Jacqueline Suppemant

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cystic Hygroma C P.O. — Interval between onset and death: 4 wks

DUE TO asbestosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pneumothorax, bilat. P. & mediastinal emphysema

DUE TO second. to inserting tracheal tube — 1/6 hr.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-24, 1949 *to* 7-27, 1949 *that I last saw the deceased alive on* 7-27, 1949, *and that death occurred at* 6.30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm H. Zuelhaus M. D.	JOHNS HOPKINS HOSPITAL	7.28.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 29, 1949	Solomons Catholic Cem	Solomons Calvert Co, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 28 1949	Huntington Williams, M.D.	A. A. Harkness & Son - Mutual	

VS 150

56E

LATKOWSKI

G76674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76674

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Frances Latkowski

2. DATE OF DEATH: July 26 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 28 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3030 O'Donnell St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	3-9-95	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Joseph Wasilke
14. MOTHER'S MAIDEN NAME: Catherine Krucek
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Auricular fibrillation
DUE TO (B) with Cardiac failure
DUE TO (C) Post operative radical mastectomy.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Syphilitic cardiovascular disease. Syphilitic aortitis.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: 7/26/49
19B. MAJOR FINDINGS OF OPERATION: Recurrent Carcinoma R. breast.
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-20 , 1949 *to* 7-26 , 1949 *that I last saw the deceased alive on* 7-26 , 1949 *and that death occurred at* 7.40 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Gordon Melow Carver M.D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: July 30 1949
24C. NAME OF CEMETERY OR CREMATORY: St Stanislaus Cemetery
24D. LOCATION (City, town, or county) (State): Dundalk Ave Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: John J. Duda
ADDRESS: 2829 Hudson St

VS 150

50

G76675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76675 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Stanislaus Lubinski**

2. DATE OF DEATH **7/25/49**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **3600 Erdman Ave.**

C. Length of stay in Baltimore **40 yrs.** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **3600 Erdman Ave.** 26-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	**White**	**Married**	**Oct. 25, 1879**	**69**		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Real Estate	**Own business**	**Poland**	

13. FATHER'S NAME **Lubinski**

14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mrs. Sophie Lubinski, 3600 Erdman Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) *Carcinoma of Prostate*
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: *4 yrs*

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10/10/45	*Carcinoma of prostate gland*	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from July 19 45 to July 25, 19 49 that I last saw the deceased alive on 7/25/49, and that death occurred at 11:20 p m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. P. Lubinski M. D.	*1945 W Balto St*	*7/28/49*

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State) ADDRESS
Burial	**July 29/49**	**Holy Redeemer Cemety.**	**4430 Belair Rd. Balto. Md.**

DATE RECEIVED BY LOCAL REGISTRAR: JUL 28 1949

REGISTRAR'S SIGNATURE: *Centurion Williams, M.D.*

25. FUNERAL DIRECTOR: *Harry A. Tuttle* ADDRESS: **2101 Edmondson Ave**

51B

G766676

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

Registered No. G766676

1. NAME OF DECEASED (Type or Print): Josephine Baczek

2. DATE OF DEATH: July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Genral Hospital

c. Length of stay in Baltimore: unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 3201 Mary Avenue 27-44

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	Widowed	5-29-1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Bland	U.S.

13. FATHER'S NAME: Andrew Papernik

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral accident — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Hypertensive cardiovascular disease ?

DUE TO

(C) Arteriosclerotic cardiovascular disease ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hemiplegia left of 3 mos duration

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-27, 1949 *to* 7-28, 1949 *that I last saw the deceased alive on* 7-28, 1949 *and that death occurred at* 10 50 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Marguerite Louise Cadle M. D.	Md. general Hospital	7/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Removal	7/28/49	St. Josephs	Chicago, Illinois

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 28 1949	Huntington Williams M.D.	Wm Cook Inc	1217 St Paul St.

93D

Chaljub

G76677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76677

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Antonio Chaljub

2. DATE OF DEATH JUL 28 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE N.Y.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New York
D. STREET ADDRESS (If rural, give location) 497 4th St

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 2-6-82

9. AGE (In years last birthday) 67 | If Under 1 Year: Months 5, Days 22 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Syria

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Alberto Chaljub

14. MOTHER'S MAIDEN NAME Georgina Francis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

16. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of lung with
DUE TO metastases to liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 7/26/49

19B. MAJOR FINDINGS OF OPERATION Carcinoma of lung

20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7.1. 1949 to 7.26 1949, *that I last saw the deceased alive on* 7.26 1949, *and that death occurred at* 7.45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE J. C. Vandell, Jr. M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED 7/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal

24B. DATE 7/29/49

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State) Cartagena S.A.

DATE RECEIVED BY LOCAL REGISTRAR JUL 28 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Clarence F. Hoffmann 1639 Broadway.

47D

G76678

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

606

G76678

Registered No.

1. NAME OF DECEASED (Type or Print): Clarence Burns

2. DATE OF DEATH: 7/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: 8 ~~Years~~ ~~Mos.~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): White Hall
D. STREET ADDRESS (If rural, give location): White Hall, Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	1875	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farm	Md.	

13. FATHER'S NAME: John Henry Burns

14. MOTHER'S MAIDEN NAME: Georgia H. Crum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Wife	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acidosis

DUE TO

(B) Diabetes Mellitus

DUE TO

(C) Peritonitis – 2ndary to perforated Bladder

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive C.V. disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/26/49	Ruptured Bladder Benign prostatic hypertrophy	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/20/ 1949 *to* 7/28/ 1949, *that I last saw the deceased alive on* 7/28/ 1949, *and that death occurred at* 8:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. J. Rhoades Jr. M. D.	University Hosp.	7/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 30 49	Wiseburg	White Hall Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	Howard S. Markline	White Hall

VS 150

137a

G76679 CERTIFICATE CORRECTED 8-15-49 ✓ X G76679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 Registered No.

1. NAME OF DECEASED (Type or Print) WILLIAM MERCHANT

2. DATE OF DEATH 7-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL

c. Length of stay in Baltimore Yrs. 10 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) HAVRE DE GRACE
D. STREET ADDRESS (If rural, give location) WARREN ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, (MARRIED) WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	COLORED		9-9-1884	64	10	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER FOR P.R.R.

10B. KIND OF BUSINESS OR INDUSTRY P.R.R.

11. BIRTHPLACE (State or foreign country) VA.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME [illegible]

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT BEATRICE (WIFE) ADDRESS WARREN ST. HAVRE DE GRACE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARCINOMA of LUNG
DUE TO with METASTASIS.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 8+ MOS.

19A. DATE OF OPERATION 9-25-49

19B. MAJOR FINDINGS OF OPERATION COLAPSED RT. LUNG. CARCINOMA WITH METASTASIS

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-17, 1949, *to* 7-28, 1949, *that I last saw the deceased alive on* 7-28, 1949, *and that death occurred at* 3:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Richard G. Martin M. D.

23B. ADDRESS Maryland General Hospital

23C. DATE SIGNED 7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8-1-49

24C. NAME OF CEMETERY OR CREMATORY St. James

24D. LOCATION (City, town, or county) (State) Havre de Grace, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 29 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Elmer E. Bullock ADDRESS

VS 150

472

G76680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

578 G76680

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lillie M. Welling

2. DATE OF DEATH July 26. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
A. STATE Md.
B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 5213 Brookwood Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Mins
female	White	married	9-6-1896	52	10	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	

13. FATHER'S NAME James J. Malone

14. MOTHER'S MAIDEN NAME Marie Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Gangrene small bowel enteritis	?
DUE TO	Mesenteric thrombosis	?
ANTECEDENT CAUSES (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Pulmonary edema, shock	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/24/49		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/20, 1949, to 7/26, 1949, *that I last saw the deceased alive on* 7/26, 1949, *and that death occurred at* 12 50A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R V Ramsey, M. D.	St. Agnes Hospital	7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Burial	7/31/49	Woodlawn	Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 29 1949	Huntington Williams, M.D.	Nathan Coldren 1217 E. Fayette St

VS 150

1 x 3

G76681

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76681

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CORDELIA KAHL

2. DATE OF DEATH July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3203 Dillon Street

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH 1875
9. AGE (In years last birthday) 74 73 — If under 1 Year: Months / Days; If under 24 hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Henry Osbourn
14. MOTHER'S MAIDEN NAME Catherine Tracey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS Mrs. Grace Kolk, 1629 Chilton St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE George S. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 7/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/30/49
24C. NAME OF CEMETERY OR CREMATORY London Park
24D. LOCATION (City, town, or county) Baltimore Md (State)
DATE RECEIVED BY LOCAL REGISTRAR JUL 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wilhelm Co Inc
ADDRESS 1217 E Fayette St

VS 151

93d

G76682

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 76682

1. NAME OF DECEASED (Type or Print): JACOB REAR

2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Balto., Inc.

c. Length of stay in Baltimore: Yrs. – Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1505 Covington St. #30 24-4

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: Oct.-1872
9. AGE (In years last birthday): 76 77
If Under 1 Year: Months 9 Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elliott
14. MOTHER'S MAIDEN NAME: Rose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): –
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: –

17. INFORMANT: Anna Smith
ADDRESS: 4029 Park Heights Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.
DUE TO
(B) Coronary Sclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pulmonary Tuberculosis + Carcinoma of Colon

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-28, 1949, *to* 7-29, 1949 *that I last saw the deceased alive on* 7-29, 1949, *and that death occurred at* 2:15a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Arthur D. Rudolph M. D.
23B. ADDRESS: Sinai Hospital.
23C. DATE SIGNED: 7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-29-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis, Inc.
ADDRESS: 2100 Eutaw Pl.

VS 150

46e

G76683

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

590

G76683
Registered No.

1. NAME OF DECEASED (Type or Print) THOMAS H. COLLIER

2. DATE OF DEATH 7/25/49

3. PLACE OF DEATH: Baltimore City, Maryland — 2215 Druid Hill Av Balto. City, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 327 E.23rd. St. 12-4

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. 30yrs — Mos. — Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	Widowed	9/15/1882	66	10	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hod Carrier	Bldg. Industry	Essex County, Va.	U.S.A.

13. FATHER'S NAME: Henry Collier

14. MOTHER'S MAIDEN NAME: Amie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	217-03-6246	Alice Miller(D)	2215 Druid Hill Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Senile Nephritis — 3 mos.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 20, 19 49, to July 25, 19 49, *that I last saw the deceased alive on* July 25, 19 49, *and that death occurred at* 5.40A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. A. Johnson M. D.	2324 Guilford Av.	July 28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/29/49	Mt. Auburn Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Lillington Williams, M.D.	Charles G. Cooper	512 N.Carrollton Av.

VS 150

83a

Dr Shutts.

G76684

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

176 Registered No. G76684

1. NAME OF DECEASED (Type or Print): Joseph William Rimbach Jr.

2. DATE OF DEATH: 7-28-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2025 W. Fayette St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 29,
D. STREET ADDRESS (If rural, give location): 4028 Walrad St. 20-8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days / Hours / Min.
M.	W.	Single	7-27-49		17

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph William Rimbach

14. MOTHER'S MAIDEN NAME: Minnie Belle Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH: 14½ hrs.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 27, 1949, *to* July 28, 1949, *that I last saw the deceased alive on* July 27, 1949, *and that death occurred at* 2:30A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul S. Mannino M. D.	Bon Secours Hospital	7/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	7/29/49	Loudon Park Cemetery	3445 Frederick Ave Bal

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	Thomas J. Kenny Inc.	1600 Hollins St

VS 150

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G76685 CERTIFICATE 8-5-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76685

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Howard Harold James Brooks

2. DATE OF DEATH July 23, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 832 Vine Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	M	1926	25 33		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
L		N C	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
?	?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		ALLEN FUNERAL HOME	- N C

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet Wound of Brain — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	HOME	1021 W. Lexington St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
7-23-49 11:12 p. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

23A. SIGNATURE	M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil L. Beyer			7-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	7/30/49	Asheville	N. Ca

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	J. F. Brown & Son	108 W Montgomery St

VS 151

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G76686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1949 G76686 Registered No.

STATE FILE NO.

1. NAME OF DECEASED (Type or Print) CHARLOTTE J. Goldenberg.

2. DATE OF DEATH July 28/49.

3. PLACE OF DEATH: a. Baltimore City, Maryland 6002 York Road.

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Same B. COUNTY Balto.Md.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

c. Length of stay in Baltimore Lifetime, Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 27-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Married	June 6.1885.	64 ~~YRS~~	1 / 22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	none	Balto.Md.	

13. FATHER'S NAME Wallace Hax.

14. MOTHER'S MAIDEN NAME Unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Eli Goldenberg. 6002 York Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Left Kidney DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C) — DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
March 1949	Carcinoma left kidney	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3/1949, 19__, to 7/26, 1949 *that I last saw the deceased alive on* 7/27, 19 49 *and that death occurred at* 6 A M *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. L. Hornstein M. D.	204 E. Biddle St	7/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 29th. 1949.	Balto? Hebrew.	Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	Davis Goldstein Co.	1902 Eutaw Pl.

VS 150

5 7 a

G76687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

E 9 1 0 G76687 Registered No.

1. NAME OF DECEASED (Type or Print) AMELIA A. VOLKERT N 808.0

2. DATE OF DEATH 27 JULY '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1911 WILKENS AVE

c. Length of stay in Baltimore LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE MD.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1911 WILKENS AVE 19-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
FEMALE	WHITE	WIDOWED	JUNE 29 1855	94		28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE		BALTO. MD.	

13. FATHER'S NAME MAHR

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO		

17. INFORMANT Mr. BOYD APPLER — ADDRESS 1911 WILKENS AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured pelvis — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

(B) Bronchopneumonia — 2 days

DUE TO

(C) none

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
William J. McClafferty M.D.
For: C. J. Lukinski, M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Home	1911 Wilkens Ave. 19-4

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
7-11-49 10 A. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Fell out of Bed.

22. *I hereby certify that I attended the deceased from* 7/25, 19 49 *to* 7/27, 19 49, *that I last saw the deceased alive on* 7/27, 19 49, *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Willen M. D.	2030 Wilkens Ave	7/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	JULY 30 '49	WESTERN	EDMONDSON AVE — LONGWOOD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	HARRY H WIPKE — 4101 EDMONDSON	406

VS 150

1960

G76688

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76688

1. NAME OF DECEASED (Type or Print): ADA ALICE MORTIMER

2. DATE OF DEATH: July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3803 Garrison Blvd. 15-10

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Sep.
8. DATE OF BIRTH: 5/31/85
9. AGE (In years last birthday): 64 — If Under 1 Year: Months / Days 27 — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): seamstress
10B. KIND OF BUSINESS OR INDUSTRY: Hutzler Bros.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Herbert Lockard
14. MOTHER'S MAIDEN NAME: Kate Jordan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT — ADDRESS: Records - US Marine Hospital, Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lymphosarcomatosis — Interval between onset and death: Unknown
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 17, 1949 *to* July 28, 1949, *that I last saw the deceased alive on* July 28, 1949, *and that death occurred at* 5:25A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson M.D.
23B. ADDRESS: US Marine Hospital, Balto. Md.
23C. DATE SIGNED: 7/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/30/49
24C. NAME OF CEMETERY OR CREMATORY: Westminster Cem.
24D. LOCATION (City, town, or county) (State): Westminster Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 29 1949
REGISTRAR'S SIGNATURE: Carrington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: John O. Mitchell & Sons 1900 E. Balto. Place

VS 150

55½

BIRTH NO. 6689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76689

1. NAME OF DECEASED (Type or Print) Ridgley, May Bell

2. DATE OF DEATH 7/28/49

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home + Hospital

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ellicott City
D. STREET ADDRESS (If rural, give location) Falls Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	6/6/1870	79	12	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Baltimore	U.S.

13. FATHER'S NAME Henry Scott

14. MOTHER'S MAIDEN NAME Sara Grimes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			Betty Lou Markel	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Arteriosclerosis — Interval between onset and death: 15 yrs

DUE TO

ANTECEDENT CAUSES

(B) Gangrene left foot — 6 months

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Arteriosclerotic Heart Disease — 15 yrs

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/23/49	Gangrene will be Left foot - Amputation	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 15, 1949 *to* July 28, 1949 *that I last saw the deceased alive on* July 28, 1949, *and that death occurred at* 10:15 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. G. Means M.D. M. D.	Church Home & Hospital	July 28, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-31-49	Good Shepherd	Howard County Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	H. C. Heinecke & Son	

VS 150

93d

476690

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 676690

1. NAME OF DECEASED (Type or Print) Miss Mary Ellen Price

2. DATE OF DEATH July 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1212 W. 41st Street
c. Length of stay in Baltimore — Yrs. 81 years — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1212 W. 41st Street 138

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	August 1, 1865	83	11	26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	—	Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Price	Catherine Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	—	Sherby E. Garrett	1212 W. 41st Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C V D — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

(B) C Decompensatem

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 1938 *to* 7-27, 1949, *that I last saw the deceased alive on* 7-27 1949 *and that death occurred at* 3:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lawrence J. Clements M. D.	3711 Falls Rd	7-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 30, 1949	Jessop	Baltimore Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

93d

G76691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76691

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mr. Millard P. Bloom

2. DATE OF DEATH July 28th 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital.
c. Length of stay in Baltimore 12 years. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore. 27-15
D. STREET ADDRESS (If rural, give location) 5710 Newbury Ave. - Balto. 9.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	4/14/87.	62	3 / 14	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Owner
10B. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas G. Bloom
14. MOTHER'S MAIDEN NAME Emma E. Plowman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 215-18-4302
17. INFORMANT Dorothy A. Parke ADDRESS 5708 Newbury Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction.
DUE TO
(B) Coronary Heart Disease.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Hypertensive, Arteriosclerotic Cardiovascular Disease.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 17th, 1949 to July 28th, 1949 *that I last saw the deceased alive on* July 28th, 1949, *and that death occurred at* 7.20 a m., *from the causes and on the date stated above.*

23A. SIGNATURE Carlos J. Castellano, M. D.
23B. ADDRESS Bon Secours Hospital
23C. DATE SIGNED July 28th 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug. 1-1949
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge
24D. LOCATION (City, town, or county) (State) Pikesville, Maryland
25. FUNERAL DIRECTOR Burgee Funeral Home ADDRESS 363 Falls Road

DATE RECEIVED BY LOCAL REGISTRAR JUL 29 1949
REGISTRAR'S SIGNATURE Tuttington Williams, M.D.

VS 150

931

G76692

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76692
Registered No.

1. NAME OF DECEASED (Type or Print): Frank Cincibus Sr.,

2. DATE OF DEATH: July 26,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
721 N. Monford Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE / B. COUNTY: Maryland, Balto, 721 N. Monford Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 721 N. Monford Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	Jan 1,1875	74	6	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist	Balto. Dry Dock	Czechoslovakia	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Marie Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		216-07-1238-A	Antonia Cincibus (wife)	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Cerebral Hemorrhage	9 days
	DUE TO	Arteriosclerosis	Unknown
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	Myocardial Damage	Unknown
	DUE TO		
	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 17, 1949, *to* July 26, 1949 *that I last saw the deceased alive on* July 26, 1949, *and that death occurred at* 11:35 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philibert Artigiani M. D.	2942 E. Fayette Street	7/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 29,1949	Oak Hill Cemetery	Honner's Lane

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR
JUL 29 1949	Huntington Williams, M.D.	Schimunek Funeral Home Inc, 2601-05-05 East Madison Street

VS 150

83a

G76693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17

Registered No. G76693

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Nellie Grier

2. DATE OF DEATH 7-26-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 126 N. Mount St.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 126 N. Mount St. 19-2

5. SEX Female
6. COLOR OR RACE Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH April 6, 1890
9. AGE (In years last birthday) 59
If Under 1 Year: Months 3 Days 20
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Matthews S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jordon McCombs
14. MOTHER'S MAIDEN NAME Amy ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Almetta Daniels ADDRESS 126 N Mount St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Uterus
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/1 19 49 *to* 7/25 19 49 *that I last saw the deceased alive on* 7/25 19 49 *and that death occurred at* 8:30 *m. from the causes and on the date stated above.*

23A. SIGNATURE R. W. McAllister Jr.
23B. ADDRESS 126 N. Mount St
23C. DATE SIGNED 7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-29-49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem
24D. LOCATION (City, Town, or County) Woods Hill Md (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm Kelso P. Williams
ADDRESS 322 N. Schroeder St.

VS 150

484

G76694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76694

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Richard Wenn

2. DATE OF DEATH July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Annapolis
D. STREET ADDRESS (If rural, give location) 112 Washington st

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	5/4/98	51	2 / 24	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Supply Clerk	U.S. Naval Academy	Annapolis, Md	U.S.A.

13. FATHER'S NAME Henry Wenn

14. MOTHER'S MAIDEN NAME Susie Mobray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure

DUE TO

(B) Coronary insufficiency & emphysema of lungs.

DUE TO

(C) Congenital narrowing right Coronary artery

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7-28, 1949, *to* 7-28, 1949, *that I last saw the deceased alive on* 7-28, 1949, *and that death occurred at* 6:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. W. S. Butler M. D.	JOHNS HOPKINS HOSPITAL	7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/1/49	Brewer Hill	Annapolis, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	Wm Reese	108 Washington St. Annapolis, Md.

VS 150

94a

To secure age is especially important. Physicians please write the name of cause clearly and legibly.

G76695

CERTIFICATE CORRECTED 11-3-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443 Registered No. G76695

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William (Barnett) Barnett — 2. DATE OF DEATH July 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 604 Baker st. 15-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored		5 1870	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		S	

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage, site unknown — 7 days
DUE TO
(B) Hypertensive Cardio-Vascular Disease — years
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-27, 1949 *to* 7-27, 1949 *that I last saw the deceased alive on* 7-27, 1949, *and that death occurred at* 10 15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Lubens M. D.	JOHNS HOPKINS HOSPITAL	7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/30/49	Mt Calvary Cemetery	H. H. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	Charles P. Law	802 Madison Ave-1

VS 150

93d

Collect age is especially important. Physician please write clearly.

✓To be checked by Med. Examiner

G76696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 9.3.0

Registered No. G76696

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret Moore — N-8-1.0

2. DATE OF DEATH 7-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West. Balt. Gen. Hosp.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 4017 Ridgecroft Rd #6 27-1

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH June 6, 1880 | 9. AGE (In years last birthday) 69 | If Under 1 Year: Months 1, Days 22 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank O'Connor

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Anna Link ADDRESS 4017 Ridgecroft Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

(B) Fracture of left femur

DUE TO

(C) Cerebral-Vascular Accident

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

A. CVD c Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY Hilda J. McClafferty for: W. K. Kammer, M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4017 Ridgecroft Rd. #6 27-1

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 7 1 49 m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? Fell during Apoplectic stroke

22. I hereby certify that I attended the deceased from 7-22-49, 19__, to 7-28-49, 19__, that I last saw the deceased alive on 7-26-49, 19__, and that death occurred at 12:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE Irene Linn Grant. M. D. | 23B. ADDRESS West. Balt. Gen. Hosp. | 23C. DATE SIGNED 7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8-1-1949 | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral | 24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 29 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Edmund W. Conklin ADDRESS 924 E. Eager St

VS 150

1862.

Consult the Causes of Death Clearly and Legibly. Physician's phone number is important. Please write

G76697

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76697

1. NAME OF DECEASED (Type or Print): Margaret F. Wilson

2. DATE OF DEATH: July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland ~~Widowed~~ *Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 923 Valley St.

C. Length of stay in Baltimore: 71 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 923 Valley St. 10-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	White	~~Widowed~~ Widowed	Oct. 18th 1877	71	9	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House work	House work, Home	Baltimore Md.	U.S.A.

13. FATHER'S NAME: John Murray

14. MOTHER'S MAIDEN NAME: Not Kown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		no	Mr. James L. Wilson	48090cville Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arterio Sclerotic heart disease. — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

DUE TO

(B) Hypertension chr. nephritis — 4

DUE TO

(C) general arterio Sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4-19-, 1949 *to* 7-27, 1949 *that I last saw the deceased alive on* 7-27, 1949 *and that death occurred at* 12.15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. A. Nicholson M. D.	2230 Eutaw Pl.	7/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 30, 1949	New Cathedral Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	Elmer W. Conklin	924 E. Eager St.

VS 150

131a

676698-339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 31

Registered No. 676698

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lela Waters.

2. DATE OF DEATH July 27, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland Balto

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 40 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 218 S. Parish St. Z 23 19-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	Negro	Divorced	Oct. 16. 1890	58	9	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Cambridge Md	U.S.A.

13. FATHER'S NAME Denward Stiles (DEC)

14. MOTHER'S MAIDEN NAME Mary Cornish

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT Records Balto. City Hospitals ADDRESS 4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
		No

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 15, 1949 *to* July 27, 1949 *that I last saw the deceased alive on* July 27, 1949, *and that death occurred at* 9.30 m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	4940 Eastern Ave.	July 28, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 30-49	Mt Calvary Cem.	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	[signature]	Elroy O. Wilson	1000 Brunty Ave

VS 150

930

G76699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76699

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Charles Anderson

2. DATE OF DEATH 7/25/49.

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore all Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2013 Harlem ave. 16-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Col.	Single	Nov. 10 1899	49	8 / 15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Anderson

14. MOTHER'S MAIDEN NAME Jennie Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Jennie Anderson ADDRESS 2013 Harlem ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	status asthmaticus	few hours
DUE TO (B)	Bronchial asthma	20 yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Idiosyncrasy to sodium amytal	?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/23 19 49 *to* 7/25 19 49, *that I last saw the deceased alive on* 7/25 19 49, *and that death occurred at* 5:34 P *m., from the causes and on the date stated above.*

23A. SIGNATURE W. A. Neumann M. D.

23B. ADDRESS Univ. Hosp.

23C. DATE SIGNED 7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 29-49

24C. NAME OF CEMETERY OR CREMATORY Mt Auburn cem.

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 29 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Elroy O. Wilson ADDRESS 1000 Brantly Md

VS 150

11 V

G76700

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

983 E G76700 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES WOOD N 803 — 2. DATE OF DEATH July 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore 12 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE Maryland — B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore — D. STREET ADDRESS (If rural, give location) 15 Arch Street 4-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Widower	Dec. 26 1902	46	6	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Nash CO. N.C.	U.S.A.

13. FATHER'S NAME: John R. WOOd

14. MOTHER'S MAIDEN NAME: Sundia Debross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: John E. Wood 1009 Edmondson Ave

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the correct age in each case.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture, skull

DUE TO (B) Sub dural hemorrhage

DUE TO (C) Contusion, brain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) In front of 11 W. Arch St. 4-2

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 7-24-49 Approx. 9 p. m.

21E. INJURY OCCURRED — WHILE AT WORK [ ] — NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Felled by fist during altercation (struck head on pavement)

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE William J. McCafferty M.D. — 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] — 23C. DATE SIGNED 7-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE July 30-49 — 24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem. — 24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 29 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — FUNERAL DIRECTOR Elroy O. Wilson — ADDRESS 1000 Bounty Lane

VS 151

168

G76701

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

584

G76701

Registered No.

1. NAME OF DECEASED (Type or Print) — MAY D. HUTCHINS

2. DATE OF DEATH — July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — Beechfield Nursing Home 6028 Old Harford Rd.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Baltimore
D. STREET ADDRESS (If rural, give location) — 142 W. Lanvale St.

11-K

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
female	white	single	1863	about 86 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Maryland	

13. FATHER'S NAME — Lewis Harman Hutchins

14. MOTHER'S MAIDEN NAME — Katherine Kennard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		no

17. INFORMANT — Mrs. Joseph I. Greene — ADDRESS — Marlyn Apts. 612 Cathedral Ave. Washington, D.C.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hepatitis — six weeks

DUE TO

(B) Cholelithiasis — six months

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Adhesions of duodenum & obstruction — 10 weeks.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June 15 1949	Cholelithiasis and adhesion about duode	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give street location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1949, *to* July 28th, 1949, *that I last saw the deceased alive on* July 25th, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ferdinand E. Mataré, M.D.	1300 N. Calvert St.	7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/30/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

126

G76702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76702

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Viola Butler Bailey

2. DATE OF DEATH July 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 616 N. Stockton St

c. Length of stay in Baltimore Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 616 Stockton St Balto. Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) [redacted] 616 Stockton St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Negro	married	Feb 7 1903	46	5	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md.	U.S.A.

13. FATHER'S NAME —

14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		—	Edward Bailey	616 Stockton

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular disease — INTERVAL BETWEEN ONSET AND DEATH 2 yrs

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY. m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 24, 1949, *to* July 27, 1949, *that I last saw the deceased alive on* July 27, 1949, *and that death occurred at* 7:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William H. Watts M. D.	515 Cathedral	7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	7/30/49	Mt Auburn	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	Geo. G. Nelson	1303 93d Pocomoke

VS 150

Please write the cause of death clearly and legibly. Correct age is especially important. Physicians, please write

G76703

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76703

Registered No.

1. NAME OF DECEASED (Type or Print) William Barrett

2. DATE OF DEATH 6:10 am 7/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jacksons Hospital

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) 2815 Eastern Avenue 1-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Aug. 21. 1905	43 yrs	11	7

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Chemical Company	Baltimore Md.	

13. FATHER'S NAME Charles Barrett

14. MOTHER'S MAIDEN NAME Gen. Shipley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Howard Barrett	2815 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) De Pirium Tremens. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Chronic Nephritis - Chronic

DUE TO Debilitation - Convulsions

Cardiac failure.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/24, 1949, *to* 7/28, 1949, *that I last saw the deceased alive on* 7/28, 1949, *and that death occurred at* 6:10 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Melvin J. Jakowski M. D.	211 Cathedral	7/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-31-49	New Cathedral	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	John P. Millington	2435 E. Oliver St

FS 150

74d

G76704

LEAS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47

G76707 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs Annie Elizabeth Sears

2. DATE OF DEATH 7-27-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 5110 Cordelia Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Md b. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 5110 Cordelia Ave 27-18

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX Female 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH Oct 23 1867 9. AGE (In years last birthday) 81 If Under 1 Year: Months 9 Days 4 If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Cook

14. MOTHER'S MAIDEN NAME Annie Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Ruth Miller ADDRESS 5110 Cordelia Ave

CAUSE OF DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio Sclerosis

DUE TO

(B) Hypertension

DUE TO

(C) Age and Exhaustion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

(A) unknown

(B) 4yrs ?

(C)

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* [redacted] *to* July 27 1949 *that I last saw the deceased alive on* 7-27 1949 *and that death occurred at* 10.35 *m., from the causes and on the date stated above.*

23A. SIGNATURE E. R. Eusor M. D.

23B. ADDRESS 7201 York Rd

23C. DATE SIGNED 7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7-30-49

24C. NAME OF CEMETERY OR CREMATORY Westminster Cem

24D. LOCATION (City, town, or county) (State) Westminster Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 29 1949

REGISTRAR'S SIGNATURE Carrington Williams, M.D.

25. FUNERAL DIRECTOR John C. Miller Inc ADDRESS 1435 E. Oliver St

VS 150

97

Medical Examiners Case

G76705
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH E 9 3 0

Registered No. G76705

N-871.0

1. NAME OF DECEASED (Type or Print): Ann M. Mengers

2. DATE OF DEATH: July 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): [redacted]. CATONSVILLE
D. STREET ADDRESS (If rural, give location): 42 Miller Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	White	married	Unknown 1871	78?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Annie M. Hogan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: William C. Mengers — ADDRESS: 42 Miller Ave.

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician: please write especially important. Physician: please write the cause of death clearly and legibly.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Inter Trochanteric Fract. Left Femur — Colle's Fracture, Left

DUE TO

(B)

DUE TO

(C) Hypostatic Pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

CERTIFICATION APPROVED BY
John R. Davis, M.D.
Per [illegible] M.D.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/23/49	Open Closed reduction - cast applied	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
accident	Home	42 Miller ave Balto 21

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
7/16/49 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Fell on wax floor

22. I hereby certify that I attended the deceased from 7/16 1949 to 7/27, 1949 that I last saw the deceased alive on 7/27, 1949, and that death occurred at 1:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank D'Arcy M.D.	St Agnes Hosp	7/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-30-49	Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	Geo. D. Farley	Baltimore & Fayette St.

VS 150

186a

CERTIFICATE CORRECTED 7-29-49

G76706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 31

G76706

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARIE JACKSON

2. DATE OF DEATH July 27, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

A. STATE MARYLAND

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE

c. Length of stay in Baltimore — Yrs. life — Mos. — Days

D. STREET ADDRESS (If rural, give location) 3145 CLIFTMONT Ave. 8-1

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 5 1896 1897

9. AGE (In years last birthday): 52

If Under 1 Year: Months 7 Days 22

If Under 24 Hours: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HAT-CHECKER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Wm. Thiel

14. MOTHER'S MAIDEN NAME: CAROLINE SCHMIDT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Carrie Kirwan ADDRESS: 2818 Kirkwood Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying; e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Essential Hypertension — indefinite

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* July 27, 1949, to July 27, 1949, *that I last saw the deceased alive on* July 27, 1949, *and that death occurred at* 6:52 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: John A. Spittel Jr M. D.

23B. ADDRESS: Mercy Hospital

23C. DATE SIGNED: 7/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 8/1/49

24C. NAME OF CEMETERY OR CREMATORY: Natwood

24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JUL 29 1949

REGISTRAR'S SIGNATURE: Lexington Williams, M.D.

25. GENERAL DIRECTOR: Wilson & Son

ADDRESS: 1217 Druid St

VS 150

83a

Please write the cause of death clearly and correct age is especially important. Physician:

G76707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76707

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT RUSSELL NORDSTROM

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore 49 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE NJ
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pleasantville
D. STREET ADDRESS (If rural, give location) RFD Route 1 Box 365

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH 5/6/29
9. AGE (In years last birthday) 20 (If Under 1 Year: Months 2, Days 23; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ET 2/c
10B. KIND OF BUSINESS OR INDUSTRY US Coast Guard
11. BIRTHPLACE (State or foreign country) New York, NY
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert Nordstrom
14. MOTHER'S MAIDEN NAME Leona Dunn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) Sept. '46 to present
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT ADDRESS Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Leukemia, myelogenous, acute.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Duration unknown

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 10, 1949, *to* July 29, 1949, *that I last saw the deceased alive on* July 29, 1949, *and that death occurred at* 7:05A m., *from the causes and on the date stated above.*

23A. SIGNATURE John L. Lewis, Jr. U.S.A. Surgeon
23B. ADDRESS Director US Marine Hospital, Balto, Md.
23C. DATE SIGNED 7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 1-1949
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State) New York N.Y.

DATE RECEIVED BY LOCAL REGISTRAR JUL 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Pollock & B. M. Walters
ADDRESS Bronx New York

VS 150

74a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G76708 ✓ G76708

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Miss Elizabeth Nettie Shook

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 15

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4753 Park Heights Ave.

c. Length of stay in Baltimore 60 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland ~~B. COUNTY~~
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-1
D. STREET ADDRESS (If rural, give location) 1834 West Fairmont Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	Oct. 15, 1874	74	9 / 14	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bookbinder- Retired	Retired	Laurel, Maryland	None

13. FATHER'S NAME Caspey Shook

14. MOTHER'S MAIDEN NAME Caroline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Mrs. Adelaide L Hawley	4753 Park Heights

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro- Vascular Hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 18 mos.
DUE TO
(B) Hypertensive Cardio Vascular Disease — 10 years
DUE TO
(C) Arteriosclerotic Cardio Vascular Disease — 10 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 20 1949 *to* July 29, 1949, *that I last saw the deceased alive on* July 28 1949 *and that death occurred at* 7 00 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Millard H. Tralond Jr. M. D.	3400 Woodbine Ave. Balt. 7, Md	7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/1/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

932

Please write plainly. Physician: please write the cause of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure age is entered in every case.

G76709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76709

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Julia A. Grant.

2. DATE OF DEATH July-29-1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 234 S. Monastery Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 56 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) 234 S. Monastery Ave 20-8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White.	Widowed.	Jan. 15-1877.	72	6 / 14	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife.	Own Home.	Elizabethtown - N. Y.	U.S.A.

13. FATHER'S NAME John Randolph.

14. MOTHER'S MAIDEN NAME Mary Lynch.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no.	no.	no.

17. INFORMANT Mrs. Julia M. Noll. ADDRESS 2345 Monastery Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Chronic Myocarditis	2 yrs.
	DUE TO		
ANTECEDENT CAUSES	(B)	Cardio Vascular Renal Disease	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO		
	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb 1947, 19__, *to* July 28, 1949, *that I last saw the deceased alive on* July 28 1949, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. H. Hamilton M. D.	4709 Fred Ave.	7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial.	Aug-1-49.	New Cathedral Cemetery	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 29 1949	Huntington Williams, M.D.	Charles J. Schaub - 3512 Frederick Ave.

VS 150

131a

Please write the cause of death clearly and legibly. Physician: please write the correct age in years. Important.

G76710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76710

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Leonard Cephas

2. DATE OF DEATH July 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2307 Madison Ave.

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2307 Madison Ave. 13-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	married	July 16, 1888	61		8

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Elevator Operator	Post Office	Vienna, Md.	U.S.A.

13. FATHER'S NAME William J. Cephas

14. MOTHER'S MAIDEN NAME Amelia Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Estelle Cephas ADDRESS 2307 Madison Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary thrombosis.	30 min.
	DUE TO Hypertension + arteriosclerosis	?
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
II	(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-20-, 1949 *to* 7-26-, 1949 *that I last saw the deceased alive on* 7-26-, 1949, *and that death occurred at* 4 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Louis H. Hamm M. D. | 23B. ADDRESS 2224 Madison Ave. | 23C. DATE SIGNED 7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/31/49	Mt. Zion	Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 29 1949 | REGISTRAR'S SIGNATURE: Huntington for Williams, MD

25. FUNERAL DIRECTOR Holland Funeral Home ADDRESS 1691 Druid Hill Ave 94a

VS 150

G76711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G76711

1. NAME OF DECEASED (Type or Print) **Andrew Mann**

2. DATE OF DEATH **7-26-49**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **2013 Sinclair La.**

c. Length of stay in Baltimore **70 Yrs.** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY **City**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **2013 Sinclair La.**

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	**White**	**Married**	**July 31st.,1869**	**79**	**11**	**25**		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Layout man	**Boiler work**	**Germany**	**U.S.A.**

13. FATHER'S NAME **John Mann**

14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	**None**	**214-10-0093A**	**Mrs.Caroline Mann**	**2013 Sinclair La.**

MEDICAL CERTIFICATION

(Please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and legibly.)

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Myocardial Failure** — Interval between onset and death: **July 7 - July 26**

DUE TO

(B) **Lobar Pneumonia**

DUE TO

(C) **Carcinomatosis Abdominis** — **√ Yes**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* **July 1** 19**49** *to* **July 26** 19**49** *that I last saw the deceased alive on* **July 26** 19**49** *and that death occurred at* **10** *P.M., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[illegible] Jos M.D.	**713 N. Charles St.**	**July 27**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	**7-30-49**	**Sacred Heart Cemetery**	**German Hill Rd.Balto:Co.Md.**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 29 1949	**Huntington Williams, M.D.**	**George J.Ruth,Inc.**	**1735 Harford Avenue**

VS 150

87 c

G76712 BALTIMORE CITY HEALTH DEPARTMENT 754 G76712

BIRTH NO. B.C. 49-11035 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Charles Peddicord

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3711 Belvedere (West)

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 3711 W. Belvedere Ave. 27-18

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W		6/2/49		1	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John J. Peddicord

14. MOTHER'S MAIDEN NAME Mary Beaven

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS J. J. Peddicord 3711 W Belvd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE George L. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED July 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/30/49

24C. NAME OF CEMETERY OR CREMATORY Cathedral

24D. LOCATION (City, town, or county) (State) Balto. City.

DATE RECEIVED BY LOCAL REGISTRAR JUL 29 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR ADDRESS C. V. Zimmerman 4611 Pk. Hgts.

VS 151

157 L

Please write the cause of death clearly and legibly. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76713

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-20-1

Registered No. G76713

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELMER L HANDY

2. DATE OF DEATH July 27, 1949 1AM

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1019 W. Lanvale Street 16-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C		1/15/1904	45	6	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Handy
14. MOTHER'S MAIDEN NAME Cora Kane
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-70-4273
17. INFORMANT Cora Handy ADDRESS 1019 W Lanvale St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location.)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 7/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 31 49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary
24D. LOCATION (City, town, or county) (State) A.A Co. Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ISAIAH L BROWN SON
ADDRESS 108 W Montgomery

VS 151

94a

Please write the cause of death clearly and legibly. Physician: please write correct age in years. Important.

G76714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

G76714 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Hansen

2. DATE OF DEATH July 27 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4022 Wilsby Ave

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 4022 Wilsby Ave COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md.

D. STREET ADDRESS (If rural, give location) 4022 Wilsby Ave 9-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Female	White	Widow	Aug 21 1872.	76	11	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Baltimore Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Christian Scholl

14. MOTHER'S MAIDEN NAME S. Heidrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Henry V. Oberender ADDRESS 36 Murdock Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arterio-sclerosis Cerebral	3
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1946 19__, *to* 7-27, 1949, *that I last saw the deceased alive on* 7-26, 1949 *and that death occurred at* 6:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE A. L. Everhart M.D. — 23B. ADDRESS 36 York Ct. — 23C. DATE SIGNED 7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE July 30 1949 — 24C. NAME OF CEMETERY OR CREMATORY Schwartz — 24D. LOCATION (City, town, or county) (State) Lonnell Pa

DATE RECEIVED BY LOCAL REGISTRAR JUL 30 1949 — REGISTRAR'S SIGNATURE Winfield Nicholas, M.D. — 25. FUNERAL DIRECTOR John C. Mason — ADDRESS 3000 E Baltimore St

VS 150

131a

G76715

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

44 ✓ G76715 Registered No.

1. NAME OF DECEASED (Type or Print): Katherine Louise Forster

2. DATE OF DEATH: 7/27/49

3. PLACE OF DEATH: (A) Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3045 Guilford Avenue

C. Length of stay in Baltimore: 92 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3045 Guilford Avenue 12-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	1/29/57	92	5	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	-------	Baltimore, Md.	

13. FATHER'S NAME: Louis Fehsenfeld

14. MOTHER'S MAIDEN NAME: Helena Peters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Louis G. Forster	3045 Guilford Av.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypostatic Pneumonia	2 days
	DUE TO Heat Prostration	
ANTECEDENT CAUSES	(B) Senile cardiovascular renal	yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Apr. 19 49 *to* July 27, 19 49 *that I last saw the deceased alive on* July 27, 19 49 *and that death occurred at* 10:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. S. Lisby M. D.	432 Cathedral Park Rd	7/28/49

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~or CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	7/30/49	Mount Carmel	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 30 1949	Huntington Williams, M.D.	H. W. Meakes and Son	605 N. Calvert St

VS 150

131a

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G76716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153 G76716 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Cecilia Becht

2. DATE OF DEATH July 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Univ Built

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ohio B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hyde Park

D. STREET ADDRESS (If rural, give location) 3057 Victoria Blvd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	2-10-89	60	7	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Patrick Cannon

14. MOTHER'S MAIDEN NAME Mary MacDonald

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Sigmoid Colon — INTERVAL BETWEEN ONSET AND DEATH: 18 mos.

DUE TO

(B) with invasion of urinary bladder and uterus

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gross Hematuria — 18 mos.

19A. DATE OF OPERATION 7/6/49

19B. MAJOR FINDINGS OF OPERATION Recurrent Carcinoma of Sigmoid & invasion of bladder & uterus

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-29-, 1949, *to* 7-24-, 1949, *that I last saw the deceased alive on* 7-24-, 1949 *and that death occurred at* 6:50 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE William E. Chase M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED 7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal

24B. DATE 7/30/49

24C. NAME OF CEMETERY OR CREMATORY Spring Grove

24D. LOCATION (City, town, or county) (State) Cincinnati, Ohio

DATE RECEIVED BY LOCAL REGISTRAR JUL 30 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR H. W. Mears & Son

ADDRESS 506 N. Calvert St.

VS 150

Via B&O R.R. Escort Mrs. Julian Woodcock

Please write the cause of death clearly and legibly. Physician: please write age is especially important.

B76717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 D 1

Registered No. 076717

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Pierce Spence

2. DATE OF DEATH July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (if not in hospital or institution, give street address or location) City Jail Infirmary

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE West Virginia
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Elkins W. Va.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Single	Apr 19. 1896	53	3	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
salesman		West Virginia	

13. FATHER'S NAME Cashley W Spence

14. MOTHER'S MAIDEN NAME Sarah E McKenzie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
10. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Occlusion	
DUE TO		
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* _____ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
William J. McClafferty M.D.		July 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	8/1/49	St Brendans	West Virginia

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 30 1949	Huntington Williams, M.D.	Charles P. Towell	2437 Edmondson Ave

VS 151

94a

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G76718

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76718

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Marie Elizabeth Kraft

2. DATE OF DEATH July 28 1949

3. PLACE OF DEATH: X Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4700 Harford Rd

b. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN, (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1125 Valley St 10-1

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Feb 1 1863
9. AGE (In years last birthday) 86
If under 1 year: Months 5 Days 27
If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Washington D C
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John G Kraft
14. MOTHER'S MAIDEN NAME Katherine Lembach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT George A Kraft ADDRESS 1125 Valley St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Anemia
DUE TO
(B) Cardio - Vascular Renal Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 3 days
(B) ?
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 1946 *to* 28 July 1949, *that I last saw the deceased alive on* 27 July 1949, *and that death occurred at* 2:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Samuel Schaffel M. D.
23B. ADDRESS 714 E Preston
23C. DATE SIGNED 29 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7/30/49
24C. NAME OF CEMETERY OR CREMATORY Baltimore
24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 30 1949
REGISTRAR'S SIGNATURE Hunter for Williams, M.D.
25. FUNERAL DIRECTOR Wilson & Ford ADDRESS 1314 Harford St

1314

Please write the cause of death clearly and legibly. Physician please write the cause of death clearly and legibly. Physician please write the cause of death clearly and legibly. Physician

BIRTH NO. 76719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76719

1. NAME OF DECEASED (Type or Print) GEORGANNA A. FELDPUSCH

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hosp.
C. Length of stay in Baltimore Yrs. Lif Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 2308 E. Preston Street 8-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Oct 5 1881	67 sml	9	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wife
10B. KIND OF BUSINESS OR INDUSTRY Hair Dresser
11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME George Feldpusch
14. MOTHER'S MAIDEN NAME Louise Keil
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Herbert Feldpusch ADDRESS 2308 E Preston St

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the correct age if especially important.

18.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic cardiovascular	
	DUE TO disease	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED July 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/1/49
24C. NAME OF CEMETERY OR CREMATORY Baltimore
24D. LOCATION (City, town, or county) Baltimore (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 30 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR William Cook Inc
ADDRESS 1210 Park Ave

VS 151

932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 76720 Registered No. G76720

1. NAME OF DECEASED (Type or Print) ALBERT J. KUMMER

2. DATE OF DEATH July 27, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 1216 St. Paul St. 11-V

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) MARRIED
8. DATE OF BIRTH 1885
9. AGE (In years last birthday) 64 sml
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Kummer
14. MOTHER'S MAIDEN NAME Adelaide P. Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Chamber Co. ADDRESS Washington D.C.

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 7/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal
24B. DATE 7/29/49
24C. NAME OF CEMETERY OR CREMATORY St Mary
24D. LOCATION (City, town, or county) (State) Washington D.C.

DATE RECEIVED BY LOCAL REGISTRAR JUL 30 1949
REGISTRAR'S SIGNATURE Williams, M.D.
25. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS Wash. D.C.

VS 15

932

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G76721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59 ✓ Registered No. G76721

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Joseph Pilachowski

2. DATE OF DEATH 7-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital

c. Length of stay in Baltimore LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 175 S. Robinson St. 1-2

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED

8. DATE OF BIRTH 5/24/1885 | 9. AGE (In years last birthday) 64 | If Under 1 Year: Months 2, Days 3 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ? | 10B. KIND OF BUSINESS OR INDUSTRY RETIRED

11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME UNKNOWN

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ?

17. INFORMANT FRANK PILACHOWSKI ADDRESS SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Uraemia	
ANTECEDENT CAUSES	DUE TO (B) Chronic Nephritis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/27/ , 19 49 *to* 7/28/ , 1949, *that I last saw the deceased alive on* 7/28/49, 19 , *and that death occurred at* 7:30 PM. *from the causes and on the date stated above.*

23A. SIGNATURE S. K. Kaan M.D. | 23B. ADDRESS 1400 N. Caroline Street | 23C. DATE SIGNED 7/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/1/49 | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer | 24D. LOCATION (City, town or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 30 1949 | REGISTRAR'S SIGNATURE Hunter Williams, M.D. | 25. FUNERAL DIRECTOR Lilly & Zeiler, Inc. | ADDRESS Balto. Md.

VS 150

131 b

Please write the cause of death clearly and correct age is especially important. Physicians:

G76722 BALTIMORE CITY HEALTH DEPARTMENT G76722

BIRTH NO. B.C. 49-01998 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) CARROLL D. WEST N-991

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Mercy Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
4323 O'Donnell Street 26-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 1 Day: Hours / Min.
Male	White	Infant	1/22/49		6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Herman West

14. MOTHER'S MAIDEN NAME Virginia Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Herman West - ADDRESS Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.)
(A) Asphyxiation
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
4323 O'Donnell St. 26/6

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
7-29-49 Approx. 7:30 a. m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR?
Found face down in bed-clothes

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X] suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED July 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/1/49	Schwartz	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 30 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Lilly & Zeile ADDRESS Balto. Md.

182a

VS 151

G76723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55

G76723

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANNA TAYLOR PARKER

2. DATE OF DEATH July 29 / 49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 212 HOMEWOOD Ter.
c. Length of stay in Baltimore 40 YRS. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 212 HOMEWOOD TER Md
B. COUNTY
C. ~~CITY~~ OR TOWN (If outside corporate limits, write RURAL and give township) BALTO. Md 12-2
D. STREET ADDRESS (If rural, give location) 212 HOMEWOOD TERRACE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	MARRIED	AUG 20 1882	66	11	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		PHILA. PENN	

13. FATHER'S NAME GEORGE B TAYLOR

14. MOTHER'S MAIDEN NAME HANNAH MARY SMEDLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT LINDLEY E PARKER ADDRESS SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the gall bladder with metastasis to liver, brain and skull — INTERVAL BETWEEN ONSET AND DEATH: 2 months.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 15 July, 1949, *to* 29 July, 1949, *that I last saw the deceased alive on* 28 July, 1949, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Douglas Lockard M. D.	802 Cathedral St.	29 July 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF [redacted] CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	July 30 / 49	Loudon Park	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 30 1949	Huntington Williams, M.D.	Henry W. Jenkins Sons Co.	4901 York Rd

VS 150

461

Write the cause of death clearly and correct age is especially important. Physician: please write this

G76724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1949

G76724

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MINNIE LINTHICUM

2. DATE OF DEATH July 28. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1180 Nanticoke St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-2
D. STREET ADDRESS (If rural, give location) 1180 Nanticoke St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Nov 30 1873	75		28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife		Baltimore	

13. FATHER'S NAME William Boyce

14. MOTHER'S MAIDEN NAME Kate Bullock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	

17. INFORMANT Lydia Torbeck ADDRESS 1180 Nanticoke St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 3days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma entire right side of face — 3years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Paralysis left side of body — Hyps. Thro.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 25 1949 *to* July 28 1949, *that I last saw the deceased alive on* July 28 1949, *and that death occurred at* 4-45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John P. Urbach Jr M. D.	1227 Wash. Blv'd	7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 1-1949	Loudon Park	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 30 1949	Huntington Williams, M.D.	Mr. Mrs. John W. Temple & Son	5311 Edmondson Ave

VS 150

54 b

Please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and correct age is especially important. Physician:

G76725 ✓ 492 G76725

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ISAAC IKE SHAFFER

2. DATE OF DEATH 7-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Levindale Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore 50 yrs Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 922 Madison Ave 11-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	White	Single	1879	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cashier		Russia	USA. ✓

13. FATHER'S NAME
Hyman Shaffer

14. MOTHER'S MAIDEN NAME
Belle ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Annie Cohen	3308 Labyrinth Road

MEDICAL CERTIFICATION

16. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Virus pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized arteriosclerosis — Period of years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ / NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-18 1949 *to* 7-28 1949 *that I last saw the deceased alive on* 7-28 1949 *and that death occurred at* 10:45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Nagel M. D.	Levindale Home	7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 31, 1949	Windsor Mill Rd Cem	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 30 1949
REGISTRAR'S SIGNATURE: Hunter Williams, M.D.

25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

VS 150

109a

Please write the cause of death clearly and legibly. Physician's special attention is especially important. Correct age is especially important.

BIRTH NO. 676726

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51

Registered No. 676726

1. NAME OF DECEASED (Type or Print) ALONZA EDWIN ROCKWELL — Rockwell, Alonza

2. DATE OF DEATH 7/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — University Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore – 13
D. STREET ADDRESS (If rural, give location): 3413 Kentucky Ave 26-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	DEC. 30 1901	47	7	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager
10B. KIND OF BUSINESS OR INDUSTRY: Bowling Alley

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edward Rockwell

14. MOTHER'S MAIDEN NAME: Mary Hoyle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-05-3155

17. INFORMANT: Mrs. Helen Rockwell
ADDRESS: 3413 Kentucky

MEDICAL CERTIFICATION

(Physician: please write the cause of death clearly and correct age is especially important. Physician should be directly responsible.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of (Pancreas?) with metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Oct. 1948
19B. MAJOR FINDINGS OF OPERATION: Carcinoma with metastases in abd. cavity
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 22, 1948, *to* 7/22, 1949, *that I last saw the deceased alive on* 7/22, 1949, *and that death occurred at* 8:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Arthur F. Hoge, Jr. M. D.
23B. ADDRESS: University Hosp.
23C. DATE SIGNED: 7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jul. 30, 49	Moreland Mem. Park	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS. INC.
ADDRESS: Baltimore Md.

VS 150

46g

To be approved by Chief Medical Examiner

G76727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Reg. No. 90-4-G76727

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Bagley — N-905.0

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 2354 Wilkins Ave. 20-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	10-31-1886	62	8 / 29	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Bagley
14. MOTHER'S MAIDEN NAME Margaret DoHerty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

Please write clearly and legibly. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture 7th Cervical Vertebra
DUE TO Fracture neck of left humerus
(B) Uremia
DUE TO Heart Failure
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
Walter W. Kemmerly
CORT. W. H. KEMMERLY

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑
SURG. OR ASST. MEDICAL EXAMINER

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Gwynn Falls Park
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Same as 21B 20-6
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 6/29/49 6:30 P. m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Pt. fell down an embankment

22. I hereby certify that I attended the deceased from 6/29, 1949, to 7/29, 1949, that I last saw the deceased alive on 7/27, 1949, and that death occurred at 8:20 A m., from the causes and on the date stated above.

23A. SIGNATURE Walter J. Bernard M. D.
23B. ADDRESS St. Agnes Hospital
23C. DATE SIGNED 7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/2/49
24C. NAME OF CEMETERY OR CREMATORY St. Francis
24D. LOCATION (City, town, or county) New York, N.Y. (State)

DATE RECEIVED BY LOCAL REGISTRAR JUL 30 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR M. Fahey & Sons ADDRESS 1827 W. North Ave.

VS 150

186a

78728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

Registered No. G76728

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY A. MONAHAN

2. DATE OF DEATH 7/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ja. Lewis Conv. Home 4203 Springdale ave.

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 2643 Maryland ave. 12-6

5. SEX Female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH Jan. 2, 1885 | 9. AGE (In years last birthday) 64 | If Under 1 Year: Months 6, Days 27 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | 10B. KIND OF BUSINESS OR INDUSTRY ---

11. BIRTHPLACE (State or foreign country) Baltimore, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank W. Monahan

14. MOTHER'S MAIDEN NAME Annie E. Buckley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ---- (If yes, give war or dates of service) ----------

16. SOCIAL SECURITY NO. none

17. INFORMANT Mrs. Frank Skirvan ADDRESS 411 Westgate Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebro vascular hemorrhage	12 hours
DUE TO (B)	Hypertension C.V.D.	12 year.
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Prerenal hemyplegia rt.	

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1946, *to* July 29, 1949, *that I last saw the deceased alive on* 7/27, 1949, *and that death occurred at* 2:25 A m., *from the causes and on the date stated above.*

23A. SIGNATURE W. N. Townsend Jr. M. D. | 23B. ADDRESS 14 E. Eager St | 23C. DATE SIGNED 7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/1/49 | 24C. NAME OF CEMETERY OR CREMATORY Cathedral | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 30 1949 | REGISTRAR'S SIGNATURE Custodian of Records, Md | 25. FUNERAL DIRECTOR Chas. J. Evans & Son Inc. | ADDRESS 118 West Mount Royal ave.

932

VS 150

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G76729 — BALTIMORE CITY HEALTH DEPARTMENT — G76729

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DANIEL ARTHUR NELSON

2. DATE OF DEATH: 7/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp.

C. Length of stay in Baltimore: 6 hrs 50 min (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Govt. - Essex
D. STREET ADDRESS (If rural, give location): 8200 Eastern Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 7/29/49
9. AGE (In years last birthday) — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.: 6 hrs 50 min

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ralph Wallace Nelson
14. MOTHER'S MAIDEN NAME: Dolores Agnes Guttenberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. ADDRESS: Guttenberger

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/29, 1949 *to* 7/29, 1949 *that I last saw the deceased alive on* 7/29, 1949 *and that death occurred at* 7:45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Iwaniski M. D.
23B. ADDRESS: St. Joseph's Hosp.
23C. DATE SIGNED: 7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-30-49
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cem.
24D. LOCATION (City, town, or county) (State): Balto., Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Connelly
ADDRESS: 418 Eastern Ave Balto 21 Md.

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Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G76730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76730

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Keith Allan Nelson

2. DATE OF DEATH July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Essex
D. STREET ADDRESS (If rural, give location) 8200 Eastern Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	July 29, 1949			1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore, Maryland	

13. FATHER'S NAME Ralph Wallace Nelson

14. MOTHER'S MAIDEN NAME Dolores Agnes Gallenberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mrs. Gallenberger	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/29, 1949 *to* 7/30, 1949, *that I last saw the deceased alive on* 7/30, 1949 *and that death occurred at* 10:00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thaddeus Dworniski M. D.	St. Joseph's Hosp.	7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-30-49	Sacred Heart	Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 30 1949	Huntington Williams, M.D.	John G. Connelly	418 Eastern Ave

VS 150

159 Balto 24 Md

G76731

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76731

Registered No.

1. NAME OF DECEASED (Type or Print): ELIZABETH BEDGAR

2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashburton Nursing Home
3520 N. Hilton Rd.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4713 Homer Ave. 27-16

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: April 7, 1860
9. AGE (In years last birthday): 89 yrs. If Under 1 Year: Months 3 Days 24 If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired seamstress
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: -

14. MOTHER'S MAIDEN NAME: Christine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. William T. Reed
ADDRESS: 5408 Reisterstown Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocardial Degen - 11 yrs
due to eration

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio sclerotic Cardio- 20 yrs
due to vascular Disease

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Senility

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: No Operation
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 28, 1948 *to* July 29, 1949, *that I last saw the deceased alive on* July 28, 1949 *and that death occurred at* ... m. *from the causes and on the date stated above.*

23A. SIGNATURE: Joshua H. Armacost M. D.
23B. ADDRESS: 6419 Windsor Mill Rd
23C. DATE SIGNED: July 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/1/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 30 1949
REGISTRAR'S SIGNATURE: Chesterfield Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

93d

Please write the cause of death clearly and legibly. Physician please write the correct age is especially important.

G76732

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76732

1. NAME OF DECEASED (Type or Print): ELLA REA WEDI

2. DATE OF DEATH: July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3315 Liberty Hgts. Ave.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 3315 Liberty Hgts. Ave. 15-38

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widow	June 18, 1870	79 yrs.	1 / 10	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Baltimore, Md.	

13. FATHER'S NAME: Joseph B. Rea

14. MOTHER'S MAIDEN NAME: Manha Arnold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		no

17. INFORMANT: Mrs. V. Duff Jones — ADDRESS: 3315 Liberty Hgts. Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Arterio Sclerosis.	several yrs
DUE TO (B)	Broncho Pneumonia	10 da.
DUE TO (C)	Cardiac Failure	5 da.
	Old age.	

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July. 15, 1949 *to* July. 28, 1949 *that I last saw the deceased alive on* July. 28, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert C. Blake M. D.	Med. Arts Bldg Balto.	7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/1/49	Loudon Park Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 30 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

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G76733

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76733

1. NAME OF DECEASED (Type or Print): WILLIAM PATRICK DEE

2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Lifetime — Yrs. 76 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arbutus
D. STREET ADDRESS (If rural, give location): 1309 Poplar Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed	Oct. 13, 1872	76	9	16		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Secretary	Catholic Order	Baltimore	U. S.

13. FATHER'S NAME: Edward Dee

14. MOTHER'S MAIDEN NAME: Mary Nixon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	212-05-9982	Mrs. Mary A. Britton	1309 Poplar Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 28, 1949, *to* July 29, 1949, *that I last saw the deceased alive on* July 29, 1949, *and that death occurred at* 1:15A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mary E. Matthews M. D.	Mercy Hospital	July 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/1/49	New Cathedral Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 30 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

94a

G76734

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76734

Registered No.

1. NAME OF DECEASED (Type or Print): Parks Miss Emma

2. DATE OF DEATH: July 29th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for Incurables

C. Length of stay in Baltimore: lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 700 W. 40th St 13-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Single	1-1-1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland (Baltimore)	U.S.A.

13. FATHER'S NAME: Josiah M. Parks

14. MOTHER'S MAIDEN NAME: Mary Emma Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO		NO

17. INFORMANT: F. N. Weff — ADDRESS: 700 W. 40th Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Paralysis Agitans — INTERVAL BETWEEN ONSET AND DEATH: 19 years

DUE TO

(B) Arteriosclerosis (generalized) — 8 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 17, 1947 *to* July 29, 1949, *that I last saw the deceased alive on* July 28, 1949, *and that death occurred at* 2 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Hampton Hagerman M. D.	214 Medical Arts Bldg.	7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/31/49	Govans Presby. Cem.	Govans, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 30 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

87 C

...ect age is especially important. Physician please write the ...e the cause of death clearly and legibly.

G76735
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 1 G76735 Registered No.

1. NAME OF DECEASED (Type or Print) **Herman H. Schilling**

2. DATE OF DEATH **July 27/49**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **5603 Winner Ave.**
c. Length of stay in Baltimore **20 yrs.** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **5603 Winner Ave.** 27-19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	**White**	**Married**	**Feb. 28,1895**	**54**	4	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Accountant		**Germany**	

13. FATHER'S NAME **Heinrich Schilling**

14. MOTHER'S MAIDEN NAME **Marie Sigmund**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		216 09 8024	**Mrs. Martha Schilling**	**5603 Winner Ave**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) **Coronary occlusion** — INTERVAL BETWEEN ONSET AND DEATH **½ hour**
DUE TO **Coronary sclerosis**

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) **Angina Pectoris**

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 2, 19**49**, to July 27, 19**49**, *that I last saw the deceased alive on* July 27, 19**49**, *and that death occurred at* 11:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herman R Hantz M. D.	**2601 Monhattan Ave**	**7/29/49**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**7/30/49**	**Lorraine Pk. Woodlawn, Md.**	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 30 1949	Funeral for Williams, M.D.	**Harry A. Dietzel**	**4101 Edmondson Ave.**

VS 150

94a

Please write plainly, with ink, using typewriter if convenient. Physician: please write the cause of death clearly and legibly. Every question must be answered; if unknown or not applicable, please state. Be sure that information given is correct and complete. Be especially careful to report correct age at death. Items 18, 19, 20, 21, 22, and 23 are important. Physician: please write

G76736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76736

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ROBERTA GROSS HOLLAND

2. DATE OF DEATH: July 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2204 Hunter Street 12-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Single	Aug 31-1928	20	10	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	.	Maryland A.A.Co	U.S

13. FATHER'S NAME: James Gross

14. MOTHER'S MAIDEN NAME: Agnes Holland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: James Gross ADDRESS: Churchton Md

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pulmonary tuberculosis	
DUE TO		
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
William J. McClafferty M.D.		7-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/30/49	Mt Calvary Bm	A.A. Co Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 30 1949	Lurlington Williams, M.D.	Haynes Sanders	1412 E. Preston St

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76737

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76737

1. NAME OF DECEASED (Type or Print) TABITHA MAGDALENA KOINER

2. DATE OF DEATH JULY-28-49

3. PLACE OF DEATH: a. Baltimore City, Maryland 3609 BELVIDERE AVE

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

c. Length of stay in Baltimore 8L Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE
a. COUNTY 3609 BELVIDERE AVE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE MD
d. STREET ADDRESS (If rural, give location) 3609 BELVIDERE AVE 27-18

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
FEM	WHITE	MARRIED	JAN 19-1863	86	6	9		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE	—	GERMANY	

13. FATHER'S NAME REV WM C MICHAEL SUMMER

14. MOTHER'S MAIDEN NAME EMILIE FRITZSCHE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		D MILLER KOINER	3609 BELVIDERE AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) Chronic Mitral Endocarditis — INTERVAL BETWEEN ONSET AND DEATH 4 yrs

DUE TO Cause unknown

ANTECEDENT CAUSES

(b) Arteriosclerosis & Degeneration Unknown

DUE TO Chronic Heart Disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(c) Age and Exhaustion

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 27 1949 *to* July 28, 1949 *that I last saw the deceased alive on* 7-27, 1949, *and that death occurred at* 12.30 *m. from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
P. B. Brust M. D.	7201 York Rd	7-28-49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or County) (State)
BURIAL	AUG-1-1949	TRINITY LUTH CEM	CRIMORA VA

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 30 1949	Thomas J. Williams, M.D.	MRS Chas G. ROHDE	2327 Edmondson Ave

VS 150

9 1 6

If the cause of death is especially important. Physician please write the cause of death clearly and legibly.

G76738

BALTIMORE CITY HEALTH DEPARTMENT 325.4

BIRTH NO. B.C.49-01788 CERTIFICATE OF DEATH Registered No. G76738

1. NAME OF DECEASED (Type or Print) Michael Henry Breighner

2. DATE OF DEATH 7-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1319 Holbrook Street

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1319 Holbrook Street 9-9

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 hours: Hours	Min.
Male	White	Single	Jan. 21st. 1949	0	6	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME Henry J. Breighner

14. MOTHER'S MAIDEN NAME Violet Marie Keller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	None	Mrs. Dorothy Kloebauer	1007 E. Preston St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Encephalitis (viral) — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO

(B) Virus Infection. — 48 hours.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hydrocephalus — 2 weeks.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 21, 1949 *to* July 29, 1949 *that I last saw the deceased alive on* 7/25, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph S. Blum M.D.	1115 N. Calvert St	7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 1st. 1949	Most Holy Redeemer	Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 30 1949 VS 150	Huntington Williams, M.D.	George J. Ruth, Inc. 1735 Harford Avenue

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76739

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76739

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill in correct age if especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Sarah E.Howard

2. DATE OF DEATH: 7-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1757 N.Gay Street
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1757 N.Gay Street

8-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Nov.1st.,1882	66	8 / 28	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore,Maryland	U.S.A.

13. FATHER'S NAME: William L.Johnson

14. MOTHER'S MAIDEN NAME: Annie L.Rhule

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	None	None

17. INFORMANT: Mr.William L.Howard Sr. ADDRESS: 1757 N.Gay St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute Cardiac dilatation

DUE TO

(B) Chronic myocarditis

DUE TO

(C) Heart failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/1 19 46, *to* 7/29 19 49, *that I last saw the deceased alive on* 7/29 19 49 *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J C Fulchman M. D.	1440 E Balto St	7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug.1st.1949	Baltimore Cemetery	E.North Avenue,Balto:Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 30 1949	Huntington Williams, MD	George J. Kuhn, Inc.	1735 Harford Avenue

VS 150

93d

G76740 G76740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 33

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SADIE E. COOPER

2. DATE OF DEATH 7-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) So. Baltimore General Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1206-8 Light St. 23-V

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W.	W.	Nov. 20, 1865	83	8	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Waters

14. MOTHER'S MAIDEN NAME ? Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Myrtle V. Cooper ADDRESS 1273 Battery Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CEREBRAL THROMBOSIS
DUE TO
(B) CEREBRAL ARTERIOSCLEROSIS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-27-19 49 *to* 7-29-19 49 *that I last saw the deceased alive on* 7-29-19 49 *and that death occurred at* 9:45 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE Hans Da Yanjian M. D. | 23B. ADDRESS S. B. G. H. | 23C. DATE SIGNED 7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8-1-1949 | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park | 24D. LOCATION (City, town or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 30 1949 | REGISTRAR'S SIGNATURE Hunter for Williams, M.D. | 25. FUNERAL DIRECTOR Flynn & Fleming | ADDRESS 1426 Light St.

VS 150

834

Please write plainly, with unfading ink. Every item of information should be entered. Do not abbreviate. Be sure to write the cause of death clearly and legibly. Physician's please write correct age in especially important.

G76741 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G76741

BIRTH NO.

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print): BETTIE McCOY HINER

2. DATE OF DEATH: JULY 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3002 W. COLD SPRING LANE
c. Length of stay in Baltimore: 59 YRS. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 15-13
D. STREET ADDRESS (If rural, give location): 3002 COLD SPRING LANE

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: FEB. 14, 1870
9. AGE (In years last birthday): 79 (If under 1 year: Months 5, Days 15; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): W. VA.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: BENJAMIN HINER
14. MOTHER'S MAIDEN NAME: MARY ANN HANSAL
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, after unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: BERTIE H. HINER — ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia of Age
DUE TO
(B) Arteriosclerotic Cardio Vasc Renal
DUE TO
(C) Secondary Anemia
malnutrition

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23A. SIGNATURE: Dr. Thos. H. Abbott M. D.
23B. ADDRESS: 4509 Liberty Heights
23C. DATE SIGNED: 7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: AUG. 1, 1949
24C. NAME OF CEMETERY OR CREMATORY: DRUID RIDGE
24D. LOCATION (City, town, or county) (State): PIKESVILLE MD.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 30 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: H. W. JENKINS & SONS CO.
ADDRESS: 9905 York Rd.

Vs 150

932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G76742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76742

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 South Road, Mt. Wash.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 69 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore 27-15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 South Road
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME FRANK JOSEPH MURPHY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Margaret Coan
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1879

8. AGE: Years	Months	Days	If less than one day
69	8	--	-- hr. --- min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business --------

FATHER
12. Name Frank J. Murphy
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Casey
15. Birthplace Baltimore, Md.

16 (a) Informant S. R. Mears
(b) Address 805 N. Calvert Street

17 (a) Burial (b) Date thereof 8/1/49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meaks and Son
(b) Address 805 N. Calvert Street

JUL 30 1949 (a) (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 July 1949, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1946, to 28 July 1949, and that I last saw him alive on 28 July 1949.

Immediate cause of death	Duration
Coronary Occlusion acute Recurrent.	17 July '49
Due to Arteriosclerotic C.V. Disease	?
Due to Chronic Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph E. Muse Jr M. D.
Address 5 West 29th St Date signed 7/28/49

932

G76743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 10.0 G76743

BIRTH NO. B.C. 49-15134

1. NAME OF DECEASED (Type or Print): BABY GIRL STOUT

2. DATE OF DEATH: 7-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland South Baltimore General

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): So Balto Gen Hosp. ,

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland , B. COUNTY Baltimore,
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 2404 E. Monument Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	7/~~29~~/49		6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	USA

13. FATHER'S NAME: Vernon F. Stout

14. MOTHER'S MAIDEN NAME: Franes Springer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
		[illegible]

17. INFORMANT: Vernon F. Stout, ADDRESS: 2404 E. Monument St.,

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Erythroblastosis fetalis — DUE TO

ANTECEDENT CAUSES

(B) ..... DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) .....

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. .....

(INTERVAL BETWEEN ONSET AND DEATH)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-23-19~~49~~ *to* 7-29-19~~49~~, *that I last saw the deceased alive on* 7-29-19~~49~~, *and that death occurred at* 8~~05~~ A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Dr Yeskey M. D.	S. B. G. H.	7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/30/49	Holy Redeemer Cem.	Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
JUL 30 1949	Huntington Williams, M.D.	Schimunek Funeral Home 2601 E. Madison St.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied as correct age is especially important. Physician please write the cause of death clearly and legibly.

161 C

FS-128619

G76744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0 1 0 G76744 Registered No.

BIRTH NO. B.C.H-49839

1. NAME OF DECEASED (Type or Print): Prestine Coard

2. DATE OF DEATH: 7-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1734 N. Dallas Street (13) 8-6

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 7, 1946
9. AGE (In years last birthday): 3 (If under 1 year: Months / Days: 1 / 24; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Presley Coard
14. MOTHER'S MAIDEN NAME: Virginia Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculous Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 3 Mos.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [x] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-29 19 49 *to* 7-29 19 49, *that I last saw the deceased alive on* 7-29 19 49 *and that death occurred at* 9:50 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Cogen M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 1 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem.
24D. LOCATION (City, town, or county) (State): A.A. County Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Pitt & Ellis Douglas ADDRESS: 1129 N. Caroline St

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G767:5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

914.3 G767:5

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WALTER BAXTER N-922

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1208 N. Caroline Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore, (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1208 N. Caroline Street 10-01

5. SEX M

6. COLOR OR RACE C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH June 1923

9. AGE (In years last birthday) 26 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) St. Matthews, S. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Artimus Baxter

14. MOTHER'S MAIDEN NAME Lugenia Stokes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Elsie Baxter, 1313 N. Bond St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Electrocution

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Industrial

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Gray Concrete Pipe Co., 6315 Eastern Ave. 26-5

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 28, 1949 Approx. 4:40 p.m.

21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR? Electrocuted while turning off electric current of vibrator--220 volts of current went through body

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED July 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal

24B. DATE 7/31/49

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State) Orangeburg, S. C.

DATE RECEIVED BY LOCAL REGISTRAR JUL 30 1949

REGISTRAR'S SIGNATURE Hunter Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Mrs. Robert A. Elliott & Dgt. 1129 N. Caroline St.

VS 151

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

676746
ES-130361

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 676746

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Audrey Ruffin
2. DATE OF DEATH: 7-28-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
C. Length of stay in Baltimore: 32 Yrs. (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 913 Sharp Street. 23-1
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Sep.
8. DATE OF BIRTH: May 18, 1889
9. AGE (In years last birthday): 60 (If under 1 Year: Months 2, Days 10; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: (D)
14. MOTHER'S MAIDEN NAME: (D)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Septicemia
DUE TO
(B) Marked Left Pyelonephritis, Chronic Passive Congestion-Marked
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Apical Fibrocasceous Tuberculosis Bilateral, Old Right Empyemia, arteriosclerotic Cardio-Vascular Disease-Marked

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: 7-16-49
19B. MAJOR FINDINGS OF OPERATION: Acute Diverticulitis With Perforation
20. AUTOPSY? YES [x] NO [ ]
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-16 19 49 *to* 7-28 19 49, *that I last saw the deceased alive on* 7-28 1949, *and that death occurred at* 6:55 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. L. Aspen M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: July 30/49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Norfolk Va.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mrs Robert G Elliott & Daughter
ADDRESS: 1124 N. Caroline St.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76747 — E 9 35.8 — G76747

BIRTH NO. G76747 — Registered No. G76747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): FRANK T. WALTOS — N-984

2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospital
C. Length of stay in Baltimore: 1 DAY (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~Maryland~~ PA.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ HOOVERSVILLE
D. STREET ADDRESS (If rural, give location): BOX 35

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	W	SINGLE	April 4, 1918	31	3	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNEMPLOYED	—	PA.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ANTHONY WALTOS SR.	CATHERINE PASIERB

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WORLD WAR II	210-01-4052	STANLEY WALTOS,	CHASE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Electrocution	
DUE TO		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Miami Beach, Bolleys Quarters, Md.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 29, 1949 m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Electrical storm / Struck by lightening bolt during

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]
23C. DATE SIGNED: July 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-2-49.	HOLY FAMILY CEM	HOOVERSVILLE, PA

DATE RECEIVED BY LOCAL REGISTRAR: JUL 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles L. Zeiler
ADDRESS: 901 S. Conkling St Balto. Md.

VS 151

G76748

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

G76748

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. Special attention is especially important.

1. NAME OF DECEASED (Type or Print): SARAH ELIZABETH EBAUGH

2. DATE OF DEATH: July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Methodist Home for the Aged 2211 W. Rogers Ave.
c. Length of stay in Baltimore: 80 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 W. Rogers Ave.

27-15

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Feb. 8, 1869
9. AGE (In years last birthday): 80 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carroll County, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Ebaugh
14. MOTHER'S MAIDEN NAME: Sarah N. Fowble

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): -
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Mrs. Mamie B. Fisher ADDRESS: 2211 W. Rogers Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 2 days

DUE TO

(B) Arteriosclerosis — 15 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1949 *to* July 27, 1949 *that I last saw the deceased alive on* July 27, 1949, *and that death occurred at* 1.0 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Arthur J Danes M. D.
23B. ADDRESS: 800 W 32nd St.
23C. DATE SIGNED: 7.30.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/31/49
24C. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem.
24D. LOCATION (City, town, or county) (State): Carroll County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 31 1949
REGISTRAR'S SIGNATURE: Hamilton Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

053a

CM. 129964 G767749 BALTIMORE CITY HEALTH DEPARTMENT G767749

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Agnes Kilduff

2. DATE OF DEATH: 7-29-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 608 Arlington Ave. 27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	march 14-1874	75	4 / 15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD.	

13. FATHER'S NAME: Henry Hengenomuehle (D)

14. MOTHER'S MAIDEN NAME: Catherine Morgan (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Records B.C.H. 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Embolism

DUE TO

(B) Arteriosclerotic Heart Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-8-49	Embolism in Right Femoral Artery	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 6-28- , 1949, *to* 7-29- , 1949, *that I last saw the deceased alive on* 7-29-1949, *and that death occurred at* 12.15AM, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	B.C.H. 4940 Eastern Ave.	7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 1, 1949	Holy Redeemer	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949		John A. Moran	3000 E. Balto St. Balto. Md

VS 150

093d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

ES-84489

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76750 (typed) G76750 (printed) Registered No. G76750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Mawell Foote

2. DATE OF DEATH: 7-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

C. Length of stay in Baltimore: 40 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 80 Winter Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Sep.	Nov. 18, 1889	59	8 / 10	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Business man

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Peter ?

14. MOTHER'S MAIDEN NAME: Sarah?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
DUE TO
(B) Hypertensive Arteriosclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-23, 1943, *to* 7-28-, 1949 *that I last saw the deceased alive on* 7-28, 1949 *and that death occurred at* 10:55 A. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 4940 Eastern Avenue

23C. DATE SIGNED: 7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/31/1949	Family Lot	Catonsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 3d 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Holland Funeral Home 1691 Druid Hill Ave.

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G76751 BALTIMORE CITY HEALTH DEPARTMENT G76764

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mapie Lipham Halsted

2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Worcester
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Snow Hill
D. STREET ADDRESS (If rural, give location): Rt. 1 Pocomoke

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		11-1-41	7	8 / 28	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Joseph Lipham

14. MOTHER'S MAIDEN NAME: Marie Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

DUE TO

(B) Torula histolytica

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 6/12, 1949, to 7/29, 1949, *that I last saw the deceased alive on* 7/29, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Andrew L. Sherr, M. D.	JOHNS HOPKINS HOSPITAL	7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Cem/or	Snow Hill Cem	Worcester Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949	Registrar of Vital Statistics, Md	Leeds Funeral Home	2008 Aliceanna

VS 4-50

43

G76752

BIRTH NO. G76752

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76752

1. NAME OF DECEASED (Type or Print): Charles Peter Van Herpt

2. DATE OF DEATH: July - 29 - 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2604 Rittenhouse Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2604 Rittenhouse Ave

c. Length of stay in Baltimore: 42 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-4
D. STREET ADDRESS (If rural, give location): 2604 Rittenhouse Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Dec-19-1873	75 Y.	7 / 10	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Galvanizer Retired	Winterfronts	Baardwyk Holland	U.S.A.

13. FATHER'S NAME: Adrianus Van Herpt

14. MOTHER'S MAIDEN NAME: Johanna Arnoldy Ter Kinderen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	Mexican Border 1916	217-09-0155	Mrs Roseline Luckett	1433 Altamont

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia Primary — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO

(B) Cardio-vascular-renal disease — 15 y.

DUE TO

(C) Hypertension — 15 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* on July - 29 - 1949, to ____, 19__, *that I last saw the deceased alive on* July - 29 - 1949 *and that death occurred at* 7.50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walther H. Sonnenfeldt M. D.	2708 Dolfield Rd Ry Rd	7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 2/49	St Marys	Annapolis Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949	Huntington Williams, M.D.	Millard Funeral Home	2008 Orleans

VS 150

1312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

BIRTH NO. G76753

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76753

1. NAME OF DECEASED (Type or Print): Edith Hurley

2. DATE OF DEATH: 7/28/45

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Balto
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore (Yrs. Mos. Days): life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): 1817 Portship

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 4, 1900
9. AGE (In years last birthday): 49
If Under 1 Year: Months / Days 24
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alonzo Lenck
14. MOTHER'S MAIDEN NAME: Irene Beck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Willard J Hurley 1817 ADDRESS Portship

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Infarction + Edema
DUE TO
(B) Myocardial Infarction
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* July 27 1945 to July 28, 1945 *that I last saw the deceased alive on* July 28, 1945, *and that death occurred at* 11:18 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Willard J Hurley M. D.
23B. ADDRESS: Sinai Hosp
23C. DATE SIGNED: 7/28/45

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 1 49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Willard Funeral Home ADDRESS 2008 Orleans

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fi... correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76754 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G76754

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LOIS MORROW
2. DATE OF DEATH: July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 708 E. 21st Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 708 E. 21st Street 9-8

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: July 25 1906
9. AGE (In years last birthday): 43 — If under 1 Year: Months / Days 5 — If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Schoenberg
14. MOTHER'S MAIDEN NAME: Matilda Hesse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Margaret Worden — ADDRESS: Towson Md

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from; natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 2/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Uhl Funeral Home — ADDRESS: 2008 Pulaski

VS 15+

93d.

G767555

ES-130304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63

G767555

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Frederick Schaub

2. DATE OF DEATH 7-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospitals

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 3211 Stafford Street 20-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Nov. 5, 1880	69-68	8	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur.	Eaton Pork. Co.	Md	

13. FATHER'S NAME Jacob Schaub

14. MOTHER'S MAIDEN NAME Barbara Gettler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	—	213-09-8810	RECORDS*BALTO. CITY HOSPITALS	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma Of The Lungs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. heart congestive Arteriosclerotic Disease With Congested Failure

INTERVAL BETWEEN ONSET AND DEATH over

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-14, 1949, *to* 7-28-49, 1949, *that I last saw the deceased alive on* 7-28, 1949 *and that death occurred at* 1:40 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE T. S. Dozier M. D. | 23B. ADDRESS 4940 Eastern Avenue | 23C. DATE SIGNED 7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 1st. 49	Western Cemetery	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949	Huntington Williams, M.D.	W. B. Wilbert's Sons	1300 Eutaw Pl.

VS 150

47d

PLEASE ... correct ... important. Physicians: please ... information should be carefully supplied. ... of death clearly and ... gibly.

G767756 BALTIMORE CITY HEALTH DEPARTMENT °G767756 56

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANNIE M MYERS "(Annie M. Myers)

2. DATE OF DEATH 7/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTO GEN HOSP

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2509 W. Baltimore St 20-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	MAY-4-1873	76	V	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Baltimore. Md	U.S.A.

13. FATHER'S NAME Henry Michael

14. MOTHER'S MAIDEN NAME unk.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No.		NO

17. INFORMANT Son ADDRESS W.T. Myers. 2509 W. Balto. St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRO VASCULAR ACC

DUE TO

(B) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/1/49 *to* 7/29/49, *that I last saw the deceased alive on* 7/25/49, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	W66th	7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 1-49	Western Cemetery	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949	Hunter for Williams, M.D.	A. R. Wisbert & Son	1300 Eutaw Place

LVS 150

933d

G767757 G767757 '57

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 1 Registered No.

1. NAME OF DECEASED (Type or Print) Mary E. Pewitt

2. DATE OF DEATH July 29 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Edgewood Convl. Home

C. Length of stay in Baltimore Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 533 Rossiter Ave 27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Mar. 4-1873	76	4	25

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Maryland	U.S.A.

13. FATHER'S NAME John Boelage

14. MOTHER'S MAIDEN NAME unk.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	None	Herbert R. Pewitt	—Same—

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Coronary occlusion

DUE TO

(B) Hypertensive arteriosclerotic cardiovascular disease

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hemiplegia.

INTERVAL BETWEEN ONSET AND DEATH: 1 hour

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑
—	—	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Jan. 1942 *to* July 29 1949, *that I last saw the deceased alive on* July 29 1949 *and that death occurred at* 6:00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. H. Brenzer M. D.	1402 E. Lanvale St	7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 1st. 49	Meadow Ridge Mem.	Laceys - Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1 1949	Huntington Williams, M.D.	G. Ellwood Sons	130 Eutaw Pl

VS 150

93d

17

G76758 BALTIMORE CITY HEALTH DEPARTMENT G76758 58

BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) HARRY Cohen

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Doctor's Hospital
C. Length of stay in Baltimore 26 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3905 Towanda Avenue 15-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Male	White	Married	1889	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shoemaker		Poland	

13. FATHER'S NAME Not Known

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Rose Cohen ADDRESS 3905 Towanda Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arterio-Sclerotic Heart Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 27, 1949 *to* July 29, 1949, *that I last saw the deceased alive on* July 29, 1949, *and that death occurred at* 7:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis Myers M. D.	2730 N Charles St	7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-31-49	United Hebrew	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949	Hunter for Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl.

93d

PLEASE WRITE ... correct age ... Item of information should be carefully supplied. The ... the cause of death clearly and ... ibly.

G76759 BALTIMORE CITY HEALTH DEPARTMENT G76759 59
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Mr. Ellis Braiterman
2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Doctor's Hospital
c. Length of stay in Baltimore 9 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2923 Windsor Avenue 15-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed	Oct. 15, 1877	71	9	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired —
10B. KIND OF BUSINESS OR INDUSTRY Retail Merchant
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? Russia
13. FATHER'S NAME Moshe
14. MOTHER'S MAIDEN NAME ~~Linsky~~ LAKA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. X
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I (A)	Myocardial infarction	1 day
DUE TO (B)	Arteriosclerotic heart disease	?
DUE TO (C)		
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Terminal pneumonia + acute congestive failure	1 day

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/26/, 1949, to 7/29/, 1949, *that I last saw the deceased alive on* 7/29/, 1949, *and that death occurred at* 12:40 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Manuel Friedman M. D. — 23B. ADDRESS 1737 E. North Ave — 23C. DATE SIGNED 7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE 7-31-49 — 24C. NAME OF CEMETERY OR CREMATORY Hebrew Mt Carmel — 24D. LOCATION (City, town, or county) Balto (State) Md

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE Hunter for Williams, M.D. — 25. FUNERAL DIRECTOR Jack Lewis Inc — ADDRESS 2100 Eutaw Pl

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150 1111-31 1949

93d

G76760 BALTIMORE CITY HEALTH DEPARTMENT G76760 60

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age, especially, is important. Physician please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): MAX BLIVESS

2. DATE OF DEATH: 7-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2600 Exeter St
C. Length of stay in Baltimore: 42 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2600 Exeter St 3-2

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 1869
9. AGE (In years last birthday): 80
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Moses
14. MOTHER'S MAIDEN NAME: Sara

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. M. Bliss ADDRESS: 2600 Exeter St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B)
DUE TO
(C) Chron. Myocarditis — 5 yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/27 20 1949 to 7/30, 1949, that I last saw the deceased alive on 7/30, 1949, and that death occurred at 10—Hm., from the causes and on the date stated above.

23A. SIGNATURE: W J Bayless M. D.
23B. ADDRESS: 7040 Eastern Av
23C. DATE SIGNED: 7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-31-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis
ADDRESS: 2100 Eastern Av

VS 150

932

G76761 BALTIMORE CITY HEALTH DEPARTMENT G76761V

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frank Weigenfish (djm)

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hopkins
C. Length of stay in Baltimore 48 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 7 N. Broadway St. 6-5

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH 1881
9. AGE (In years last birthday) 68 If under 1 Year: Months Days If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Not Known
14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Rose Greenspon ADDRESS 2034 E. Fayette

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not omit any item. If unknown, state so. Do not guess or estimate. Do not abbreviate. Do not use ditto marks. Do not write above the lines. Be sure to fill in the cause of death clearly and legibly. Physician: please write the cause of death in terms of disease and not in terms of mode of dying, such as heart failure, asphyxia, anemia, or uremia. Indicate the duration of each cause. Be sure to answer all questions. If there is no physician in attendance, or if he does not sign, the funeral director must report the death to the local registrar at once. Please write plainly, with unfading ink. Every item of information should be carefully supplied. Do not omit any item. If unknown, state so. Do not guess or estimate. Do not abbreviate. Do not use ditto marks. Do not write above the lines. Be sure to fill in the cause of death clearly and legibly. Physician: please write the cause of death in terms of disease and not in terms of mode of dying, such as heart failure, asthenia, anemia, or uremia. Indicate the duration of each cause. Be sure to answer all questions. If there is no physician in attendance, or if he does not sign, the funeral director must report the death to the local registrar at once. Please write plainly, with unfading ink. Every item of information should be carefully supplied. Do not omit any item. If unknown, state so. Do not guess or estimate. Do not abbreviate. Do not use ditto marks. Do not write above the lines. Be sure to fill in the cause of death clearly and legibly. Physician: please write the cause of death in terms of disease and not in terms of mode of dying, such as heart failure, asthenia, anemia, or uremia. Indicate the duration of each cause. Be sure to answer all questions. If there is no physician in attendance, or if he does not sign, the funeral director must report the death to the local registrar at once.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C. V. Disease
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* ~~Insp. & Inq.~~ Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE C. P. Sulkowski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED July 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 7-31-49
24C. NAME OF CEMETERY OR CREMATORY Hebrew Herring Run
24D. LOCATION (City, town, or county) (State) Datto Md
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR JUL 31 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc. 2100 Eastern Ave
93d

BIRTH NO. G76762

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76762

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): FLAX, LENA

2. DATE OF DEATH: JULY 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2111 Callow Ave 13-2

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1883
9. AGE (In years last birthday): 66 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Not known
14. MOTHER'S MAIDEN NAME: Not known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mitchel Stevens ADDRESS: 2111 Callow Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac failure
DUE TO
(B) Hydropneumothorax, Right
DUE TO
(C) Carcinoma of Trachea

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 18, 1949, *to* July 22, 1949, *that I last saw the deceased alive on* JULY 21, 1949, *and that death occurred at* 3:20 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: P. Leonard Derrer M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: JULY 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7/30/49
24C. NAME OF CEMETERY OR CREMATORY: Herring Run
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1949

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HELEN A HAND.

2. DATE OF DEATH JULY 29 1949.

3. PLACE OF DEATH:
A. Baltimore City. Maryland WINDSOR COURT APART.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2111 Garrison Blvd.
c. Length of stay in Baltimore LIFE. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE HOPKINS APARTMENT.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE CITY.
D. STREET ADDRESS (If rural, give location) ST PAUL &31ST STREET. 12-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	SINGLE	Jan.17,1886	63	6 / 12	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Traffic Clerk	C.& P. Tel. Co.	Baltimore, Md.	

13. FATHER'S NAME Edward I. Hand

14. MOTHER'S MAIDEN NAME Catherine B. Lennon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Wm. H. Martin	2111 Garrison Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) CARCINOMIA OF RIGHT BREAST	1946.
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) METASTASIS OF LUNG RIGHT.	1949.
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	PARALYSIS OF LEFT VOCAL CHORD.	1946.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
SEPTEMBER 9 1946	CARCINOMIA SCLEROSIS.	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JANY 1 1949, *to* JULY 29, 1949, *that I last saw the deceased alive on* JULY 29 1949 *and that death occurred at* 9.30P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas. F. Hamilton M.D.	3013 ST PAUL STREET.	JULY 30 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-1-1949	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949		G. Howard Strong	3207 W. North Ave.,

VS 150

050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76764 BALTIMORE CITY HEALTH DEPARTMENT 5103 76764

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MRS REBECCA JANE ROEMER

2. DATE OF DEATH July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 23rd & Calvert Sts.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) Cambridge Arms Apts Balto. 18, Md. 12-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	Widow	Oct 6, 1869	99	9	xx		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME Anthony Hedley
14. MOTHER'S MAIDEN NAME Mary Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown No
16. SOCIAL SECURITY NO. None
17. INFORMANT Miss Lillian M. Roemer ADDRESS Cambridge Arms Apts Balto. 18, Md.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Perforation of Ascending Colon (due to Volvulus) — INTERVAL BETWEEN ONSET AND DEATH —
DUE TO
(B) ASHD, Advanced —
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 15, 1949	Perforation of Ascending Colon	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* July 19, 1949, *to* July 28, 1949, *that I last saw the deceased alive on* July 28, 1949, *and that death occurred at* 5:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard R Beard, M. D.	Union Memorial Hospital	7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-1-49	Green Mount	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams, M.D.	Elwood Morgan Co.	Balto.

VS 150

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G76765 BALTIMORE CITY HEALTH DEPARTMENT E931.3 G76765

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BOHDAN HALUSZCZYNSKY N-9810

2. DATE OF DEATH 7-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
St. Joseph's Hospital

c. Length of stay in Baltimore 2 Months (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 2215 E. Pratt St. 1-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 hours: Hours	Min.
M	W	Married	August 23-1906	42	11	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Meat Presser	Meat Packing House	?	

13. FATHER'S NAME
Michael Haluszczynsky

14. MOTHER'S MAIDEN NAME
Johanna Tereszkiewicz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	213-30-0115	Irene Haluszczynski	2215 E. Pratt St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Heat Stroke
DUE TO
(B)
DUE TO
(C)

II ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Meat Packing Plant

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3800 E. Balto. St.(Esskay Meat Packing

21D. TIME (Month) (Day) (Year) OF INJURY July 27, 1949 Approx. 4 P. m.

21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR? Plant) 26-44 Excessive heat

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED July 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Aug. 1-1949	St. Michaels Ukraine	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949	Huntington Williams, M.D.	George A. Weber	705 South Ann Street

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every item of information should be carefully supplied. Every item of information should be carefully supplied

BALTIMORE CITY HEALTH DEPARTMENT — 163 — Registered No. 46766

BIRTH NO. G76766

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print): Harry Williams

2. DATE OF DEATH: July 29-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2446 W. Balt St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

c. Length of stay in Baltimore: 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2446 W Balt. St 20-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Mar. 17-1879	70	4	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Brakeman	B & O. R. R.	Baltimore. Md	U.S.

13. FATHER'S NAME: Edward Williams

14. MOTHER'S MAIDEN NAME: Mathilda Kramer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mrs Laura J. Williams	

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma, left lung — INTERVAL BETWEEN ONSET AND DEATH: 4 months ?
DUE TO

ANTECEDENT CAUSES

(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 25, 1949 *to* July 29, 1949 *that I last saw the deceased alive on* July 29, 1949, *and that death occurred at* 6 00 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathan Rosenau M. D.	206 S. Gilmor St.	7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 1-1949	New Cathedral	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949	Kenneth Williams, M.D.	Geo. L. Beyard Jr	1512 Hollins St

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G76767 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76747

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Adolph Sobel

2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: 38 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4324 York Road 27-11

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: June 21 1895 | 9. AGE (In years last birthday): 54 | If under 1 Year: Months 1, Days | If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant

10B. KIND OF BUSINESS OR INDUSTRY: Soda Cafe

11. BIRTHPLACE (State or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Do not Know

14. MOTHER'S MAIDEN NAME: Do not Know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. (If yes, give war or dates of service)

SOCIAL SECURITY NO.

17. INFORMANT: H. H. Sobel ADDRESS: Newland Road

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: William F. Kelbach M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: July 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 8/1/49

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): 4401 Belair Road

DATE RECEIVED BY LOCAL REGISTRAR: JUL 31 1949

REGISTRAR'S SIGNATURE: Pennington for Williams, M.D.

25. FUNERAL DIRECTOR: J. J. Fahey & Son ADDRESS: 131 Light St

VS 151

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G76768 BALTIMORE CITY HEALTH DEPARTMENT G76768
BIRTH NO. CERTIFICATE OF DEATH Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

1. NAME OF DECEASED (Type or Print): Israel C. Mathews
2. DATE OF DEATH: July 29, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2041 Druid Park Drive
c. Length of stay in Baltimore: 25 years (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland; B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2041 Druid Park Drive 13-8
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: October 13-1876
9. AGE (In years last birthday): 72 (If Under 1 Year: Months 9, Days 16; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Wm. E. Hooper & Sons Co.
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Israel C. Mathews
14. MOTHER'S MAIDEN NAME: Clarinda Waters
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-10-3453
17. INFORMANT: Fulton A. Mathews ADDRESS: 2041 Druid Park Drive

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Thrombosis	2 mos.
DUE TO (B)	Cerebral Arteriosclerosis	
	Generalized Arteriosclerosis	10 yr.
DUE TO (C)	arteriosclerotic Cardio-Vascular Disease	1 yr.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1948, *to* July, 1949 *that I last saw the deceased alive on* July 23, 1949, *and that death occurred at* 7:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: L. Kuleintz, M.D. M. D. | 23B. ADDRESS: 244 N. Hilton St. | 23C. DATE SIGNED: 7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: August 1, 1949 | 24C. NAME OF CEMETERY OR CREMATORY: Prospect Hill | 24D. LOCATION (City, town, or county) (State): Front Royal, Virginia

DATE RECEIVED BY LOCAL REGISTRAR: JUL 31 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

VS 150

932

Saurbier
2128 W. North

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C 76769

Registered No. C 76769

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES E. SHULER

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2944 Keswick Road.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2944 Keswick Road. 13-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	May 28, 1869	80	4	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Penna R.R.	York, Pa.	U.S.A.

13. FATHER'S NAME Edward Shuler.

D. MOTHER'S MAIDEN NAME Alice Nice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Mary E. Shuler ADDRESS 2944 Keswick Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 7 yrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1949 *to* July 29, 1949 *that I last saw the deceased alive on* July 29, 1949, *and that death occurred at* ____ m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benj Saurbier M. D.	2128 W. North Ave	7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 1949	Lorraine Park	Windsor Mill Rd Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949	Huntington Williams, M.D.	Faustina E. Donovan	3818 Roland Ave

93d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

Dr. Marston
516 Cathedral St.

G76770 BALTIMORE CITY HEALTH DEPARTMENT G76770 70

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PLEDA BURKE. 2. DATE OF DEATH July 28 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3152 Remington Ave
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-7
D. STREET ADDRESS (If rural, give location) 3152 Remington Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	white	widow	Nov 10 1883	65	9	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Isaac Saylor.
14. MOTHER'S MAIDEN NAME Emma Moser.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT George M. Saylor ADDRESS 3152 Remington Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardiac Dilation — INTERVAL BETWEEN ONSET AND DEATH: Few Minutes

DUE TO

(B) Myocarditis. — 3-4-1998

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	no injury	no injury

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
no injury m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	no injury

22. *I hereby certify that I attended the deceased from* 7-28- , 1949, to July 28, 1949, *that I last saw the deceased* ~~alive~~ *on* July 28, 1949, *and that death occurred at* 4.00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James Graham Marston, M.D.	516 Cathedral St.	7-30-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
V	Aug 1/49	Druid Ridge	Pikesville, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949	Huntington Williams, M.D.	Eustace E. Bowman	3818 Roland

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

JS 150

93 2

over

Gobeli ✓ ✓ ✓

G76771 BALTIMORE CITY HEALTH DEPARTMENT 54 G76771

BIRTH NO. B.C.H-37726 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) Robert Gobeli

2. DATE OF DEATH July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL

c. Length of stay in Baltimore 3 Yrs. ~~Mths~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN Essex (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 33 Compass Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	white	single	Dec. 6 1945	3	7	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant	none	Baltimore, Md.	

13. FATHER'S NAME Donald Gobeli

14. MOTHER'S MAIDEN NAME Emma Andrews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	—	Parents	

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Dehydration + Shock.	2D
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Epidemic Vomiting?	5D
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	DUE TO (C)	

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* July 29, 1949, to July 30, 1949, *that I last saw the deceased alive on* July 30, 1949, *and that death occurred at* 4:05 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles T. Henderson M. D.	University Hospital	7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7-31-49	St. Michaels Cem.	Belair Rd Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949	Thurlington Williams, M.D.	John B Connelly	418 Eastern Av

118

US 160

FOR WHITE PRINTS, WITH UNFADING INK. Every item of information should be carefully supplied. Please write correct age is especially important. Physician: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76772 ✓ 43 G76722 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): AMERICO PACIARELLI

2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: 30 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1119 Granby Street 3-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Mar 14. 1906	43.	7 / 13	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY: Cumberland Express Co
11. BIRTHPLACE (State or foreign country): Buffalo New York
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Pasiarelli
14. MOTHER'S MAIDEN NAME: Josephine Placentino
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Georgia Pasiarelli ADDRESS 131 Pleasant Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Thrombosis of Brain Stem
DUE TO
(B) Hypertension C. V. Disease
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 1. 1949.
24C. NAME OF CEMETERY OR CREMATORY: Holy Ghost Cemetery
24D. LOCATION (City, town, or county) (State): Frederick md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 31 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Wendell J Appel ADDRESS: 812 S Highland Ave

VS 151

93d 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G76773 G76773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Vitak

2. DATE OF DEATH: July 28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2614 E Madison

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2614 E. Madison St.

C. Length of stay in Baltimore: 52 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gaetano
D. STREET ADDRESS (If rural, give location): 2614 E Madison

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Aug 17, 1869	79	11	11

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Bohemia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Peter

14. MOTHER'S MAIDEN NAME: Mary Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Joseph Vitak ADDRESS: 2614 E Madison

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 26, 1949, to July 28, 1949 *that I last saw the deceased alive on* July 27, 1949, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Pekorny M. D. | 23B. ADDRESS: 2200 E Madison St | 23C. DATE SIGNED: 7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Aug 1/49 | 24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer | 24D. LOCATION (City, town, or county) (State): Balto.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 31 1949 VS 150 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Finch Beachley | ADDRESS: 9009 Chester

940

Please write the cause of death clearly and legibly. Physician please write the exact age is especially important.

G76774 — G76774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Richard H. Sibley Jr
2. DATE OF DEATH: 7/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 817 Kennedy Ave
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 817 Kennedy Ave 7-1-49

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 9/28/1889
9. AGE (In years last birthday): 59 — If Under 1 Year: Months 10, Days 1 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Radio
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard H. Sibley Sr
14. MOTHER'S MAIDEN NAME: Mary S. Massey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mildred R. Sibley — ADDRESS: 817 Kennedy Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia, Bilat bronchial — INTERVAL BETWEEN ONSET AND DEATH: ?18 hrs
DUE TO
(B) Chr. rheumatoid arthritis — 18 yrs.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 28 July, 1949 to 29 July, 1949 that I last saw the deceased alive on 29 July, 1949, and that death occurred at 8:10 p m., from the causes and on the date stated above.

23A. SIGNATURE: Fred Agee Jr M. D.
23B. ADDRESS: 7873 St Paul
23C. DATE SIGNED: 7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/1/49
24C. NAME OF CEMETERY OR CREMATORY: Westorn Cem
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Pott Co F.M. Walters — ADDRESS: Baltimore Md

FRED B. AGEE, JR.

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Item 9: If under one year, or one day, state age in hours or minutes. Item 17: Informant: please write the correct address clearly and fully. Item 18: Physician: please write the cause of death clearly and legibly. Every item must be answered. If unknown, write UNKNOWN in ink. Every item is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76775 — Registered No. G76725

1. NAME OF DECEASED (Type or Print): Frank Waterson Kilver — 2. DATE OF DEATH: 7/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 530 N. Charles St
C. Length of stay in Baltimore: 1 year (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: W Va — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wheeling
D. STREET ADDRESS (If rural, give location): 1625 Jacob St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	4/21/1900	49	3	9		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Car Foreman	Rd R.R.	Wheeling W Va	

13. FATHER'S NAME: Edward Kilver Sr
14. MOTHER'S MAIDEN NAME: Sadie Boyce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Harry Schmeichel, Wheeling W Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/1/49
24C. NAME OF CEMETERY OR CREMATORY: Greenwood Cem
24D. LOCATION (City, town, or county) (State): Wheeling W Va

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949
REGISTRAR'S SIGNATURE: Thornton Williams, M.D.
25. FUNERAL DIRECTOR: Hoff & B. M. Walton, Assistant Stucky

94a

Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76776 BALTIMORE CITY HEALTH DEPARTMENT G76726

BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Jennie Lowenberg

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2805 Hilton Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shriners Nursing Home 2805 N. Hilton Rd. Baltimore Md.

c. Length of stay in Baltimore: Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) 2703 Ulman Ave. 15-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Widowed	Mar 15, 1873	76	4	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Baltimore, Md. U.S.A.	

13. FATHER'S NAME: Abraham Jones

14. MOTHER'S MAIDEN NAME: Henrietta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Carlyn Appel ADDRESS: 2703 Ulman Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carbon Monoxide accident

DUE TO

(B) Art. sclerosis

DUE TO

(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 1947 *to* July 29, 1949, *that I last saw the deceased alive on* July 29 1949, *and that death occurred at* 8:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE Dr Bernfeld M. D. | 23B. ADDRESS Maryland Apts | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 31, 1949	Hebrew Friendship	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JUL 31 1949 VS 150

REGISTRAR'S SIGNATURE: Emerson Williams, M.D.

25. FUNERAL DIRECTOR: Wm. H. Sondheim & Co. ADDRESS: 1902 Eutaw Pl.

83a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76777 (over) G76777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) George Schooler

2. DATE OF DEATH July 28-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1913 Eutaw Pl. Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wilcght Rest Nursing Home

c. Length of stay in Baltimore 10 Yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 125 B. COUNTY St. Balto. Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 1913 Eutaw Pl. X3-3

D. STREET ADDRESS (If rural, give location) 1913 Eutaw Place

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 3-22-1873

9. AGE (In years last birthday) 76 If Under 1 Year: Months 4, Days 6. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fruit Dealer.

10B. KIND OF BUSINESS OR INDUSTRY Veg + Produce

11. BIRTHPLACE (State or foreign country) Davenport Iowa

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Winfield Schooler

14. MOTHER'S MAIDEN NAME Kate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Wilcght Rest Nursing Home ADDRESS 1913 Eutaw Pl.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Degeneration

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH ?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 22 1949 *to* one time 19 *that I last saw the deceased alive on* July 22 1949 *and that death occurred at* 3802 *m., from the causes and on the date stated above.*

23A. SIGNATURE W. R. Johnson M. D.

23B. ADDRESS 403 Medart Bldg

23C. DATE SIGNED 7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation

24B. DATE Aug-1-49

24C. NAME OF CEMETERY OR CREMATORY London Park Cem

24D. LOCATION (City, town, or county) (State) Frederick Md Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JUL 31 1949

REGISTRAR'S SIGNATURE Registrar for Baltimore, Md.

25. FUNERAL DIRECTOR David R. Marks

ADDRESS 1907 Eutaw Pl.

93d.

Please write in ink. Entry of information known to attending physician is especially important. Physician: please write the cause of death clearly and correct age is especially important.

Dr Valock Blvd bil 3689 ✓ (over) 6

1227 Wash Blvd G767.8 G76778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76778

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY T WHITE

2. DATE OF DEATH July 29/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1913 Eutaw Place

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wilight Nursing Home

c. Length of stay in Baltimore 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md b. COUNTY Balto City

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto City 1913 Eutaw Place

d. STREET ADDRESS (If rural, give location) 925 Washington Blvd 1913 Eutaw Place

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	July 18 1875	74	0	11

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	Painter	Penna	

13. FATHER'S NAME John S White

14. MOTHER'S MAIDEN NAME Hannah Pettit

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	218-10-5550	Walter White	1836 Bond St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchogenic Carcinoma right middle lobe with extension to right upper lobe — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Chronic pulmonary fibrosis with senile emphysema — 6 year

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 10 1949 *to* July 29 1949, *that I last saw the deceased alive on* July 29 1949, *and that death occurred at* 9:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John P. Valock Jr M. D.	1227 Wash Blvd	7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 1949	London Park	Frederick Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949	Thomas Tom Williams, M.D.	Daniel R Manion	1902 Eutaw Place

47c

Please write the cause of death clearly and legibly. Physician: please write the exact age in each case. This information is especially important.

G76779 ✓ 1948 G76779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76779 Registered No.

1. NAME OF DECEASED (Type or Print) William Correa N-805.0

2. DATE OF DEATH July 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore 6 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1323 Park Ave. 11-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W White	married	May 9, 1914	35		21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Salesman	N.J.	U.S.

13. FATHER'S NAME Wm H. Correa

14. MOTHER'S MAIDEN NAME Edna Sanford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Henry F. Fleming	1430 Johns Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured sacrum

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Bridge

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) North Ave. Bridge over Jones Falls

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 29, 1949 m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Jumped from bridge

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐.*

23A. SIGNATURE William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED July 30 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 1 '49	David Ridge	Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949	Washington Williams, M.D.	John O. Mitchell Sons	1600 Eutaw Place

VS 151

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76780 — Registered No. G76780

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert Bruce Lindsay (dim)

2. DATE OF DEATH: July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 608 S. Hanover St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug 7, 1906
9. AGE (In years last birthday): 42 — If Under 1 Year: Months 11, Days 23 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Worker
10B. KIND OF BUSINESS OR INDUSTRY: Edw G Fick Co
11. BIRTHPLACE (State or foreign country): Washington Co, Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Frank Lindsey
14. MOTHER'S MAIDEN NAME: Rosie Nunley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-28-3193
17. INFORMANT: Campbell Funeral Home — ADDRESS: Abingdon, Va.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute pulmonary edema.
DUE TO
(B) Acute alcoholism.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Thos S. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: July 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: July 31, 49
24C. NAME OF CEMETERY OR CREMATORY: Abingdon, Va.
24D. LOCATION (City, town, or county) (State): Abingdon, Va.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949
REGISTRAR'S SIGNATURE: Thomas Worthington Williams, M.D.
25. FUNERAL DIRECTOR: William Cook Inc. — ADDRESS

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G76781 S.H. Term ✓ Y E931.2 G76781

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76781

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GUY N. STARK — N-981-c

2. DATE OF DEATH: July 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: 10 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westport
D. STREET ADDRESS (If rural, give location): 1616 Doolittle Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	Sept. 10, 1903	45	10 / 17	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Deluca-Davis Co.	Odessa N. Y.	

13. FATHER'S NAME: William Stark

14. MOTHER'S MAIDEN NAME: Carrie Nichols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
None	076 05 5976	Mrs. Margaret E. Cunningham	702 Days La. Elmira, N.Y.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heat Stroke — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Public	Babe Ruth Stadium, 33rd Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Approx. July 27, 1949 3:10 p.m.	WHILE AT WORK [X] NOT WHILE AT WORK [ ]	Collapsed while working for the Leland Construction Co. 9-3

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
William J. McClafferty M.D.		July 28, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	July 31, 1949	Laurel Hill Cem.	Elmira, N. Y.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 31 1949	Huntington Williams, M.D.	William Cook, Inc.	1217 St. Paul St.

VS 151

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G76782

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

G76782 Registered No.

1. NAME OF DECEASED (Type or Print) James Irby JAMES FRITZ IRBY

2. DATE OF DEATH July 28, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. [redacted] Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland general Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore 50yrs (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 413 South Hanover Street 22-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed?	unKn 1867	82 82yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
In private business	Owner All-Metals Welding Co.	Danville Va. Virginia	U.S.A.

13. FATHER'S NAME unknown ? Irby

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		none	C.A. Phillips employee	2515 Liberty Parkway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage accident + cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: about 5 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic and hypertensive cardiovascular diseases — unknown

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus uremia auricular fibrillation + cirrosis — unknown

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-24 1949 *to* 7-28, 1949 *that I last saw the deceased alive on* 7-27, 1949, *and that death occurred at* 12 10 Am., *from the causes and on the date stated above.*

23A. SIGNATURE Marguerite Louise Candler M. D. | 23B. ADDRESS Maryland general Hospital | 23C. DATE SIGNED July 28, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 1. 1949	Crownhill Cem.	Salem, Indianna

DATE RECEIVED BY LOCAL REGISTRAR JUL 31 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. Huntington Williams, M.D. | 25. FUNERAL DIRECTOR HENRY SANDER & SONS. INC. ADDRESS Baltimore Md.

VS 150

61

Correct age is especially important. Physician, please write the cause of death clearly and legibly.

G76783

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51 0 5

G76783 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr. Robt. Moffett

2. DATE OF DEATH: July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5112 Norwood Rd

C. Length of stay in Baltimore: 3 mo. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Kent
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chestertown Md.
D. STREET ADDRESS (If rural, give location): Washington Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: July 17-1860
9. AGE (In years last birthday): 89
If Under 1 Year: Months / Days: 14
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): merchant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kent Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jeremiah V. Moffett
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no

17. INFORMANT: Robert V. Moffett ADDRESS: Chestertown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

DUE TO

(B) Arterio-sclerotic C. V. Disease — 6 m.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Partial Intestinal Obstruction — 3 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 12, 1949 *to* July 31, 1949, *that I last saw the deceased alive on* July 30, 1949, *and that death occurred at* 8 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Carl A Benson M.D.
23B. ADDRESS: 5111 York Rd.
23C. DATE SIGNED: July 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 2-1949
24C. NAME OF CEMETERY OR CREMATORY: Chester Cem.
24D. LOCATION (City, town, or county) (State): Chestertown Md

DATE RECEIVED BY LOCAL REGISTRAR: JUL 31 1949
REGISTRAR'S SIGNATURE: Temperton Williams, M.D.
25. FUNERAL DIRECTOR: J. Willis Wells
ADDRESS: Chestertown Md

93d

Please write the cause of death clearly and legibly. Physician's age is especially important.

G76784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 1

G76784 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LOUISA BARBARA HAAS

2. DATE OF DEATH July 29,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1015 Lyndhurst St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1015 Lyndhurst St. 16-8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widow	March 29,1866	83	4			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Washington, D.C.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Schlect	Elizabeth (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	Edwin L. Haas, 2601 Lauretta Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1½ day

DUE TO

(B) generalized arteriosclerosis — yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-27-43, 19__, *to* 7-29-49, 19__, *that I last saw the deceased alive on* 7-29-49, *and that death occurred at* 8 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry S. Gimpel M. D.	2703 Edmondson Ave	7-30-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 1 1949	Huntington Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

83a

Write the cause of death clearly and legibly. Physician: please write the exact age if especially important.

G767785

G767785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Waskey, Elmer

2. DATE OF DEATH 7-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 817 N. Brice St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 1 Day: Hours	If Under 1 Hour: Min.
M	White	Widowed	Nov. 24, 1881	67	8	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sheet Metal Worker	Kerstner Co.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME Benjamin Waskey

14. MOTHER'S MAIDEN NAME Catherine Black

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypertensive Cardio-vascular Disease	yrs.
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) Diabetes mellitus	yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-31, 1949 *to* 7-31, 1949 *that I last saw the deceased alive on* 7-31, 1949, *and that death occurred at* 1:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. J. Laham M.D.	Franklin Sq. Hosp.	7-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/3/49	Knibbs	Westminster Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Wilson Cook Inc	1214 Druid Pk

VS 150

061

Please write the cause of death clearly and legibly. Physician: please write especially important. Please write

G767785

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

17° Registered No. G767786

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LOUISE MAASBERG

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital (d.o.a.)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1010 N. Central Avenue 10-1

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH March 26, 1875

9. AGE (In years last birthday) 74 (emw) | If Under 1 Year: Months 4 | Days 3 | If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles G.Maasberg

14. MOTHER'S MAIDEN NAME Pauline Fischer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS Anne Poteel, 1014 N. Central Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast, right

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED July 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/1/49

24C. NAME OF CEMETERY OR CREMATORY Immanuel

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 1 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS William Cook, Inc.

VS 151

O.K.O

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G76787

JL- 21647

BIRTH NO. -

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76787
Registered No.

1. NAME OF DECEASED (Type or Print) Charles Hampe — E903:7 - N - 801.0

2. DATE OF DEATH 7-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore
(If outside corporate limits, write RURAL and give township) 27-17
D. STREET ADDRESS (If rural, give location) 3038 W. Garrison Ave. -B. C. Hosp.Inf.

5. SEX M
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) Wid.
8. DATE OF BIRTH Oct. 13, 1877
9. AGE (In years last birthday) 71
If under 1 year: Months 9, Days 16
If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Francis Hampe
14. MOTHER'S MAIDEN NAME Laura Garsuch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT B. C. H. Records, ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — Bronchopneumonia
DUE TO Acute bronchitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Arteriosclerotic Heart Disease

(C) Arteriosclerosis, generalized Skull fracture, left occipital bone.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Hospital room
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore City Hospitals Infirmary Bldg. Room 214
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 7-19-49 m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY Ooccur? fell walking across room

22. *I hereby certify that I attended the deceased from* 3-6, 19 37 *to* July 29, 19 49 *that I last saw the deceased alive on* July 29, 19 49, *and that death occurred at* 11.25 PM *from the causes and on the date stated above.*

23A. SIGNATURE C. L. Cozler M. D.
23B. ADDRESS 4940 Eastern Ave.
23C. DATE SIGNED 8-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 1, 1949
24C. NAME OF CEMETERY OR CREMATORY Baltimore
24D. LOCATION (City, town, or county) (State) Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 1 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm Cook Inc
ADDRESS St Paul & Preston Baltimore Md

VS 150

Please write the cause of death clearly and legibly. Physician's: please be especially careful that the correct age is given.

186a

CERTIFICATE CORRECTED 8-10-49

6788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 9310 G76788

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Michael Dolan. N-9813

2. DATE OF DEATH: 7/30/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctors Hospital

c. Length of stay in Baltimore: Yrs. 7 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1258 GLYNDON AVE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE MD
D. STREET ADDRESS (If rural, give location): 1258 GLYNDON AVE 21-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White.	married.	SEPT. 16 1889	59	10	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
OFFICE CLERK	REVERE COPPER & BRASS INC	IRELAND	U S

13. FATHER'S NAME: JAMES M. DOLAN

14. MOTHER'S MAIDEN NAME: SUSAN MC GUAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	215-10-0051	MARY A. DOLAN	1258 GLYNDON AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Heart Prostration — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-29-, 1949 *to* 7-30-, 1949; *that I last saw the deceased alive on* 7-30 1949, *and that death occurred at* 8:50 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis J Sloan Jr M. D.	2730 N Charles St	7/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	AUG 4-49	CATHEDRAL	BALTIMORE MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Bernard C. Hoale	1215 E West St

VS 150

191

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

6789

BIRTH NO. D.C. 49-15352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

60.5

G76789

Registered No.

1. NAME OF DECEASED (Type or Print) Baby Boy Mierkiewicz

2. DATE OF DEATH July 31, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 231 E. Collington Ave 1-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year, last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White		7-30-49				19½	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME Francis Mierkiewicz

14. MOTHER'S MAIDEN NAME Sophie Gromacka

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial hemorrhage

DUE TO

(B) prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 30 30 1949 *to* July 31, 1949 *that I last saw the deceased alive on* July 31, 1949 *and that death occurred at* 2 30 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William W. Haines M. D.	JOHNS HOPKINS HOSPITAL	8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 1/49	Holy Rosary	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Fred W. Ogaganski 160a

VS 150

G76730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33

G76730 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Mills

2. DATE OF DEATH July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 67 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 404 E. Federal St 12-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	married	2-27-1882	67	5	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor		Md	

13. FATHER'S NAME George B. Mills

14. MOTHER'S MAIDEN NAME Catherine Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Hemorrhage,	6 hrs
DUE TO	(B) Cerebral arteriosclerosis yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Lung ? Carcinomatosis	mos

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-15, 1949, *to* 7-28, 1949, *that I last saw the deceased alive on* 7-28, 1949, *and that death occurred at* 6 04P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Lukens M. D.	JOHNS HOPKINS HOSPITAL	7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 1, 1949	Mt. Calvary	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave.

VS 150

47D

Please write the cause of death clearly and legibly. Physician: please write correct age is especially important.

G76791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76791

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Augustus Garfield Brown

2. DATE OF DEATH: July 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4306 Dewey Ave.

c. Length of stay in Baltimore: 67 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4306 Dewey Ave 27-14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Aug. 10 1881	67	11	18

10A. USUAL OCCUPATION (Give kind of work done during most working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Butler	Wholesale silver	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Samuel C. Brown

14. MOTHER'S MAIDEN NAME: Rachel Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-10-4664 Mrs.

17. INFORMANT: Ruth J. Brown ADDRESS: 4306 Dewey Ave.

MEDICAL CERTIFICATION

Write the cause of death clearly and correct age is especially important. Physician: please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio-Vascular Renal Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Ex Lanatrin

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from June 2 1949 to July 26th 1949 that I last saw the deceased alive July 26 1949, and that death occurred at 11:15 a.m., from the causes and on the date stated above.

23A. SIGNATURE: B. L. Hughes M. D.

23B. ADDRESS: 1413 Druid Hill Ave

23C. DATE SIGNED: July 29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 8/1/49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

24D. LOCATION (City, town or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS: 1631 Druid Hill Ave. 1310

VS 150

6792

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76792

Registered No.

1. NAME OF DECEASED (Type or Print): Minnie Duchon

2. DATE OF DEATH: July 28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 430 N. Highland Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
c. CITY OR TOWN: Balto. (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 430 N. Highland Ave. 26-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widow	Jan. 19-1858	91	6	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Germany	U. S. A.

13. FATHER'S NAME: August Goemmer

14. MOTHER'S MAIDEN NAME: Phiffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Wm. DuBois	430 N. Highland Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic cardiovascular	
	DUE TO (B) disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Senility	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August, 1947, to July 28, 1949, *that I last saw the deceased alive on* July 27, 1949, *and that death occurred at* 2:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Andrew Allers M. D.	3503 Fait Ave.	7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 1-49	Baltimore Cem.	North Ave. & Gay St. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	John A. Miller	2334 Jefferson St.

VS 150

93d

Please write the cause of death clearly and legibly. Physician's special attention is especially important. Please write

G76793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76793 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Catherine E. Driver — 2. DATE OF DEATH July 30, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1013 Russell St.

c. Length of stay in Baltimore Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore —
D. STREET ADDRESS (If rural, give location) 1013 Russell St 21-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White —	Widowed	Nov 17 1859	89	9	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife —	—	Baltimore, Md	U.S.A.

13. FATHER'S NAME William Keller

14. MOTHER'S MAIDEN NAME Christine Bach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	Miss Amelia M. Keller	(Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Respiratory failure	
	DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	Arteriosclerotic + Hypertensive Cardiovascular Renal disease	
	DUE TO		
	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 29, 1949 *to* July 30, 1949, *that I last saw the deceased alive on* July 30, 1949 *and that death occurred at* 4:10 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Shorofsky M. D. M. D.	601 N. Monroe St.	7/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 3, 1949	Mt. Olivet Cem.	Balto, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	P. Howard Evans	1900 S. Charles St., Baltimore 30, Md.

VS 150

13/a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G76794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 v 1

Registered No. G76794

BIRTH NO.

1. NAME OF DECEASED (Type or Print) — Catherine J. REID

2. DATE OF DEATH — July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — 507 N. Fort Ave.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Baltimore
D. STREET ADDRESS (If rural, give location) — 507 N. Fort Ave. 24-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W.	Widow	Jan. 1, 1879	70	6	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	

13. FATHER'S NAME — ? Smith

14. MOTHER'S MAIDEN NAME — Josephine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS — Mrs. Myrtle Kaufman (Bright) Home

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease - — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE — George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED — 7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 2, 1949	Western Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	A. Howard Evans	1400 S. Charles St. Balto. 30, Md.

VS 151

932. A. Howard Evans

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G76795

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76795 Registered No.

1. NAME OF DECEASED (Type or Print): MARY MIEDWIG

2. DATE OF DEATH: July 30 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 326 St Dunstans Rd

c. Length of stay in Baltimore: 50 ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 326 St Dunstans Rd 77-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W.	Widowed	June 29 1866	83	1	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Germany	U.S.A.

13. FATHER'S NAME: William Ose

14. MOTHER'S MAIDEN NAME: Mary —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT: Mrs John MacDonald ADDRESS (same)

MEDICAL CERTIFICATION

(Please write the cause of death clearly and correct age is especially important. Physician:)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1946 *to* 30 July, 1949 *that I last saw the deceased alive on* ——, 19——, *and that death occurred at* ——m., *from the cause and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. H. Keen M. D.	6701 York Rd Balto 12 Md.	30 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 2 1949	Druid Ridge Cem	Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Henry W. Jenkins Sons Co	4905 York Rd

VS 150

93d

G76796

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1 8 G76796
Registered No.

1. NAME OF DECEASED (Type or Print) FRANK ALISEA

2. DATE OF DEATH July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 127 S. Poppleton St. 18-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	7/6/75	74		22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Smithman		Md.	USA

13. FATHER'S NAME Louise Alisea

14. MOTHER'S MAIDEN NAME H annah Heberla

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WWI	Unknown	Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Specify age is especially important.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	1- Recticulum cell sarcoma left testicle postoperative, recurrent (1/22/41)	8 yrs
DUE TO (B)	2- Metastasis, generalized, abdominal	6 mos
DUE TO (C)	3- Hydronephrosis, right	6 mos

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 23, 1949, *to* July 28, 1949, *that I last saw the deceased alive on* July 28, 1949, *and that death occurred at* 8 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J.E. Van Ackeren, Medical Director M.D.	US Marine Hospital, Balto, Md.	7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	Aug. 1, 1949	National	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Frederick A. Coles	1313 W. Baltimore St

VS 150

051C

676797

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 676797

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DAVID WELTON Wellons

2. DATE OF DEATH: July 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1211 E. Lexington Street

C. Length of stay in Baltimore: 35 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1211 E. Lexington Street 5-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Married	Aug. I5 I892	56	11	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ivory Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unkown
14. MOTHER'S MAIDEN NAME: Unkown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Martha Wellons ADDRESS: I520 Mc Elderry St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio-
DUE TO Vascular Disease
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: William J. Mc Clafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. I. 49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Elroy O. Wilson I000 Brantly Ave

VS 151

93d

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G76798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64 G76798 Registered No.

JL* -130608 BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ruth Hill

2. DATE OF DEATH July 30, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1733 Orleans St. 6-5

5. SEX F
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Dec. 7, 1930
9. AGE (In years last birthday) 18 — If under 1 Year: Months 7, Days 23; If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md. Balto.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Solomon Hill
14. MOTHER'S MAIDEN NAME Sally Briggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT B. C. H. Records, ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Severe Preeclampsia
DUE TO
(B)
DUE TO
(C) Hypertension arising in pregnancy

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION 7-28-49
19B. MAJOR FINDINGS OF OPERATION Cesarean Section
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 27, 1949 *to* July 30, 1949, *that I last saw the deceased alive on* July 30, 1949 *and that death occurred at* 12.15 *from the causes and on the date stated above.*

23A. SIGNATURE C. S. Cozen M. D.
23B. ADDRESS 4940 Eastern Ave.
23C. DATE SIGNED 7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug. 2. 49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 1 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Elroy O. Wilson 1000 Brantly Ave

1 VS 50

1446

G76799 BIRTH NO. CERTIFICATE ADDED CERTIFICATE CORRECTED

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76799 Registered No.

1. NAME OF DECEASED (Type or Print): MARGARET MAG GIE HIGH

2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1912 Riggs Avenue
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1912 Riggs Avenue 16-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	widowed	April 9, 1869	80	3	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Baltimore, Md.	

13. FATHER'S NAME: Patrick Gill

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
--		--

17. INFORMANT: Mrs. Lorretta M. Smith ADDRESS: 1912 Riggs Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
William J. McClafferty M.D.		7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Western Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, MD	WM. J. TICKNER & SONS	Balto., Md.

VS 151

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676800

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 676800

1. NAME OF DECEASED (Type or Print): Dr. WILLIAM F. GAKENHEIMER

2. DATE OF DEATH: July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 800 Washington Blvd.
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 800 Washington Blvd. 21-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Married	May 20, 1887	62 yrs.	2 / 8	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pharmacist
10B. KIND OF BUSINESS OR INDUSTRY: OwnDrug Store
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Christian Gakenheimer
14. MOTHER'S MAIDEN NAME: Charlotte Heckel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Jennie Gakenheimer
ADDRESS: 800 Wash. Blvd.

MEDICAL CERTIFICATION

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.
DUE TO
(B) Hypertensive Cardiov Vascular
DUE TO
(C) Renal Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 27, 1949, *to* July 28, 1949, *that I last saw the deceased alive on* July 27, 1949, *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John P. Ulrich, Jr. M. D.
23B. ADDRESS: 1227 Wash. Blvd
23C. DATE SIGNED: 7-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/31/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS :50

1314

G76801

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No. G76801

1. NAME OF DECEASED (Type or Print): Idabel Conney Tuyney

2. DATE OF DEATH: July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4808 Gwynn Oak Ave. -7-
C. Length of stay in Baltimore: 47 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. ~~COUNTY~~
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, -7- 28-2
D. STREET ADDRESS (If rural, give location): 4808 Gwynn Oak Avenue

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov. 28, 1873
9. AGE (In years last birthday): 75 — If under 1 Year: Months 8 Days 2 — If under 24 hours: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker - Mother
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland (Princes Anne)
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frank Conney
14. MOTHER'S MAIDEN NAME: Emeline Robinson Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Raymond G. Tuyney ADDRESS: 404 Dunmyr Rd. -12 Balt.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years

DUE TO

(B) Hypertensive Cardiovascular Disease — 3 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Paralytic Ileus — 96 hours

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 3 1948 *to* July 30, 1949 *that I last saw the deceased alive on* July 30 1949 *and that death occurred at* 9:35 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Millard T. Tuckard Jr. M. D.
23B. ADDRESS: 3400 Woodbine Ave. Balt. 7, Md.
23C. DATE SIGNED: 7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/2/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

93d

G76802

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 90850 G76802

1. NAME OF DECEASED (Type or Print): Virginia Eckert Campbell

2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U. S. Marine Hospital

c. Length of stay in Baltimore: Yrs. 4 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Owings Mills
D. STREET ADDRESS (If rural, give location): Ritters Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	Dec. 12, 1909	39	7	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Eckert

14. MOTHER'S MAIDEN NAME: Clara Elizabeth Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unkn

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Records - US Marine Hospital, Balto., Md. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Malignant hypertension — INTERVAL BETWEEN ONSET AND DEATH: 12 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cardiac enlargement; pleural effusion; uremia; nephrosclerosis; hemorrhage into gastro-intestinal tract.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Jul 25, 1949, *to* July 29, 1949, *that I last saw the deceased alive on* July 29, 1949, *and that death occurred at* 10:08 m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson M. D.	U.S.Marine Hospital, Balto., Md.	July 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Woodlawn	Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Wm. J. Tickner & Sons, North & Pa. Balto

VS 150

131a

BIRTH NO. 778803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 Registered No. G76803

1. NAME OF DECEASED (Type or Print): Herman Sweeny Atchison

2. DATE OF DEATH: 29 July 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimine 18
D. STREET ADDRESS (If rural, give location): 3401 Greenway - Eden Hall Apts 12-2

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 24 Sept 1880
9. AGE (In years last birthday): 68
If Under 1 Year: Months 10 Days 5
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contact man - Personnel Relations
10B. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel

11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Dorsey Atchison

14. MOTHER'S MAIDEN NAME: Blanche Hermon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 091-09-0283

17. INFORMANT: Patient
ADDRESS

MEDICAL CERTIFICATION

(Please write the cause of death clearly and correct age if especially important. Physicians: please write legibly.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive Cerebral Hemorrhage — Interval between onset and death: 3 hrs.

DUE TO

(B) Hypertensive arteriosclerotic cardiovascular disease

DUE TO

(C) Acute passive congestion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 00 PM 25 July 1949, *to* 11 45 P m. 29 July, 1949, *that I last saw the deceased alive on* 29 July, 1949, *and that death occurred at* 11 45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert L Pierce, M. D.
23B. ADDRESS: Owensboro Memorial Hosp.
23C. DATE SIGNED: 7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 8/1/49
24C. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24D. LOCATION (City, Town, or county) (State): Owensboro, Kentucky

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949
REGISTRAR'S SIGNATURE: Tuntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. J. Tickner & Sons, Inc. Balto. Md.
ADDRESS

VS 150

93d

G76804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76804

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SHAFFER, MISS CORA H.

2. DATE OF DEATH JULY 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTIMORE, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home for INCURABLES - 700 W. 40th St.

c. Length of stay in Baltimore — Yrs. life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN Baltimore
D. STREET ADDRESS (If rural, give location) Formerally of 2401 Elsinore Ave. 15-38

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH Nov. 8, 1862 | 9. AGE (In years last birthday) 86 yrs | If Under 1 Year: Months 9, Days 23 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher. | 10B. KIND OF BUSINESS OR INDUSTRY Balto. Dept. Education

11. BIRTHPLACE (State or foreign country) Balto. Md. U.S.A. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George E. Shaffer.

14. MOTHER'S MAIDEN NAME Sarah White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT S. E. Ross - ADDRESS 700 W. 40th Street.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Coronary Sclerosis — about 1946
DUE TO
(C) Arteriosclerotic Cardio-Vasc. Dis. with left hemiplegia — about 1946

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arthritis Deformans Multiplex — about 1940

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 24th 1949, to July 31st, 1949, *that I last saw the deceased alive on* July, 1949, *and that death occurred at* 5.40 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE Thomas Cowan W.M. M. D. | 23B. ADDRESS 11 E. Chase St. Balto. 16 | 23C. DATE SIGNED 7/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/3/49 | 24C. NAME OF CEMETERY OR CREMATORY Baltimore | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 1 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Wm. J. TICKNER & SONS | ADDRESS Balto., Md.

VS 150

936

G76805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 3

G76805 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Stringer, William Taylor

2. DATE OF DEATH: July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2, Md.
D. STREET ADDRESS (If rural, give location): 204 E. Gittings Ave. 27-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	3/18/81	68	4	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mgr. Coal Division	Railroad	Hillsborough, Va.	

13. FATHER'S NAME: Wm. R. Stringer

14. MOTHER'S MAIDEN NAME: Roberta Kemp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Mrs. Athol Stringer ADDRESS: 204 E. Gittings Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Senile arteriosclerosis with Hypertension — Omit; 8:00 A.M. 7-31-49

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 31, 1949 *to* July 31, 1949, *that I last saw the deceased alive on* July 31, 1949 *and that death occurred at* 5:00 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T. N. Cooperenog M.D.	St. Joseph's Hospital Balto	7-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 3, 1949	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Burlington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

0834

w Mentzer ✓ x

G76806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 / G76806 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) AUGUSTINE STEPHEN WIEST

2. DATE OF DEATH July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Colonial Nursing Home

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Catonsville
D. STREET ADDRESS (If rural, give location) 819 Braeside Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: June 10, 1887
9. AGE (In years last birthday): 62
If Under 1 Year: Months 1 Days 20
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Philadelphia, Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: (Unknown) Wiest

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Augustine Wiest, Jr., 819 Braeside Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Hypostatic pneumonia~~ Hemiplegia, Complete
DUE TO Brain clot Arteriosclerosis
(B) DUE TO HC VD
(C) Hypostatic pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/29, 19 49 *to* 7/30, 19 49 *that I last saw the deceased alive on* 7/30, 19 49 *and that death occurred at* 4:30 A m. *from the causes and on the date stated above.*

23A. SIGNATURE Daniel W. Mentzer M. D.
23B. ADDRESS 3089 Evergreen Ave
23C. DATE SIGNED 8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/2/49
24C. NAME OF CEMETERY OR CREMATORY: Meadow Ridge,
24D. LOCATION (City, town, or county) (State): Dorsey, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 150

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G76807 129700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

581.0 G76807

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLARA FREIMILLER
Clara Freimiller

2. DATE OF DEATH July 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 40 YRS. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-4
D. STREET ADDRESS (If rural, give location) 2410 Hudson St.

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 13, 1889
9. AGE (In years last birthday) 60 yrs
If Under 1 Year: Months 5, Days 15
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY - - -

11. BIRTHPLACE (State or foreign country) St. Georges Delaware
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William T. Carrow
~~William Carrow~~

14. MOTHER'S MAIDEN NAME Margaret. Hopkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT Records Balto City Hospitals ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema
DUE TO
(B) Laennecs Cirrhosis. With Ascites.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebro Vascular Arteriosclerosis.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 16, 1949, *to* July 28, 1949, *that I last saw the deceased alive on* July 28, 1949 *and that death occurred at* 5.15 PM *from the causes and on the date stated above.*

23A. SIGNATURE C. S. Rogers M. D.
23B. ADDRESS B. C. H.
23C. DATE SIGNED July 28, 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug. 1. 1949
24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 1 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR HENRY SANDER & SONS. INC.
ADDRESS Baltimore Md.

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E931.G76808

Registered No. 981.0

G76808
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Albert Reely (Reely) N

2. DATE OF DEATH 7/29/45

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp

C. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE
620 N. Howard St
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 620 N. Howard St 7-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Divorced	June 3 1910	39	1 / 26	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman

10B. KIND OF BUSINESS OR INDUSTRY Bakery

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Walter Reely

14. MOTHER'S MAIDEN NAME Louisa Engel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —

(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 216-10-2126

17. INFORMANT Mrs Louisa Reely ADDRESS 620 N. Howard St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension

DUE TO

(B) Heat Stroke

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 28, 1945 *to* July 29, 1945 *that I last saw the deceased alive on* July 29, 1945, *and that death occurred at* 7:20 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE Leonard Katz M. D.

23B. ADDRESS Sinai Hosp

23C. DATE SIGNED 7/29/45

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Aug 1 '45

24C. NAME OF CEMETERY OR CREMATORY Loudon Park

24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR AUG 1 1945

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Philip J. Henry & Sons

ADDRESS 2024 Orleans St

VS 150

191

BIRTH NO. G76809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 G76809
Registered No.

1. NAME OF DECEASED (Type or Print) PALMA MARIE ROSINOLA

2. DATE OF DEATH JULY 31 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hospital for Women of Md.

c. Length of stay in Baltimore 9 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 26-44
D. STREET ADDRESS (If rural, give location) 5004 EAST EAGER ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
FEMALE	White	MARRIED	MAR 3 1898	51	4	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	—	POTTSVILLE, PA.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
PETER FRESLONE	MARY —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		—	PATIENT	(HOSPITAL RECORDS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMMORHAGE — INTERVAL BETWEEN ONSET AND DEATH: 24 HRS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) HYPERTENSIVE C-V DISEASE — ?

DUE TO

(C) OBESITY — ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

POST OPERATIVE — 48 HRS

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
JULY 29 1949	MYOMATA UTERI	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JULY 1, 1949 *to* JULY 31, 1949 *that I last saw the deceased alive on* JULY 31, 1949, *and that death occurred at* 7:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James D. McCook Jr. M. D.	1014 ST. PAUL ST.	July 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
	July 3/49	St. Jeromes Cem.	Tamaqua Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
	Huntington Williams, M.D.	Philip Henrigbons	3024 Orleans St

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93d

MEDICAL EXAMINER'S CASE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

Registered No. G76810

G76810

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Rose Collins

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 415 Homeland Avenue 27-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Fe.	White	Widowed	4/6/1869	80	3	23	-	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper	Mrs. James I. Brown	Baltimore, Maryland	

13. FATHER'S NAME Richard McGee

14. MOTHER'S MAIDEN NAME Ann Riley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral hemorrhage	6 hrs.
DUE TO (B)	Hypertension - arteriosclerotic vascular disease	?
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Fracture left femur	1 month

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-29-49	Fracture left femur	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Home	415 Homeland Ave - 27-11

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
June 26 1949 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Fall - Had a dizzy spell and fell to floor

22. *I hereby certify that I attended the deceased from* June 26, 1949, *to* July 29, 1949, *that I last saw the deceased alive on* July 29, 1949, *and that death occurred at* 1:00PM., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Isaac Kreigin M. D.	1400 N. Caroline Street	7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Holy Cross Cem	Ritchie Highway

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
8/2/49	Huntington Williams M.D. Commissioner	J. J. Daley & Sons	1318 Lydia St

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Approved. [illegible]

93D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76811

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary E. Scott

2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2313 Pennsylvania Ave. 14-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Married	July 1892	57		

10A. USUAL OCCUPATION (Give kind of work, even during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Scott
14. MOTHER'S MAIDEN NAME: Martha Washington
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
16. SOCIAL SECURITY NO.
17. INFORMANT: Harry Scott ADDRESS: 2313 Penna Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial degeneration
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-1-49	Arbutus Memorial Arbutus	Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mr. Peter R. Williams ADDRESS: 332 N. Schroeder St

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93D

G76812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76812

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNA C. KISSNER

2. DATE OF DEATH: 7/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1033 N. HISQUITH ST.

c. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1033 N. HISQUITH ST. 10-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
F	W	SINGLE	2/21/1874	75	5	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SOCIAL WORKER	HOME	MARYLAND	U.S.A.

13. FATHER'S NAME: BEN KISSNER

14. MOTHER'S MAIDEN NAME: APPOLONIA SCHWAB

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	NONE	?	LOUISE BARTHOLME	SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Carcinoma of Colon	6 mos.
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 1949 *to* July 29, 1949, *that I last saw the deceased alive on* July 29, 1949, *and that death occurred at* 10:00 *P.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. H. Krenzer M. D.	1428 Kenyon Rd	8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8/2/49	HOLY REDEEMER	BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	WILLY & ZEILER INC.	BALTO.

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G76813

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

24-1

Registered No. G76813

1. NAME OF DECEASED (Type or Print): JAMES ~~HROMADNIK~~ HROMADNIK

2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 1370 Andrea Street 24-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	single	May 21, 1908	41	2	8	.	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank Hromadnik

14. MOTHER'S MAIDEN NAME: Mary (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Albert Vacovsky - ADDRESS: 1370 Andrew St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute congestive cardiac failure	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	DUE TO (C)	

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: July 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/1/49	Holy Redeemer Cemetery	Belair Rd. Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949

REGISTRAR'S SIGNATURE: Tuntington Williams, M.D.

25. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 2601-3-5 E. Madison St.

93E

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Please write the cause of death clearly and legibly. Physician: please fill in all items. Important: Physician, please sign as soon as possible.

676814

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

676814

Registered No.

1. NAME OF DECEASED (Type or Print): THOMAS J. ~~VEYSCRARK~~ VEYSTRK

2. DATE OF DEATH: July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 633 S. Linwood Avenue

C. Length of stay in Baltimore: 55 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 633 S. Linwood Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 1 day: Hours	Min.
Male	White	widowed	Dec. 23, 1888	60	7	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bartender		Czechoslovakia	

13. FATHER'S NAME: Peter Veystrk

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Martin T. Veystrk, ADDRESS: 313 Gusryan St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Sacred Heart Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

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93d

G76815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 4720

G76815

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANTOINETTE HLAVIN

2. DATE OF DEATH: 7/31/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 921 N. Streeper St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 65 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 921 N. Streeper St. 7-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Oct. 20, 1877	71 years	9 / 11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York City

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Drimal

14. MOTHER'S MAIDEN NAME: Theresa Urban

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Barbara Meads, dght, ADDRESS: 108 N. Rose St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 30, 1949 *to* July 31, 1949 *that I last saw the deceased alive on* July 30, 1949, *and that death occurred at* 12 10 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert B. Tunney M. D.	920 So Paul St	7-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/3/49	Holy Redeemer Cemetery	4430 Belair Rd. Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 2601-3-5 E. Madison St.

VS 150

108

G76816

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 43

Registered No. G76816

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William L. Brown

2. DATE OF DEATH 7-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1000 W. Lafayette Ave.

c. Length of stay in Baltimore 45 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17.
D. STREET ADDRESS (If rural, give location) 1000 W. Lafayette Ave. 16-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	8-13-1884	64	11	17

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Beth. Steel Co.	Keysville, Va.	U.S.A.

13. FATHER'S NAME Lee Brown

14. MOTHER'S MAIDEN NAME Mary Moten

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Laura Brown - 1000 W. Lafayette Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypertensive Cardio Vascular Renal Complication DUE TO Chronic Valvular Disease.	3/1/49 - 7/31/49
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/11/49, 19__, *to* 7/31/49, 19__, *that I last saw the deceased alive on* 7/30, 1949, *and that death occurred at* 2:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jack L. Julian Jr. M.D.	511 N. Schroeder St.	8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-3-49.	Mt. Calvary	A.A. Co. Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Wm. A. Jackson	916 Penna. Ave.

VS 150

93d

G76817

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76817

1. NAME OF DECEASED (Type or Print): Sarah B. Dawson

2. DATE OF DEATH: 7/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Home of Our Lady
c. Length of stay in Baltimore: 30 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-2
D. STREET ADDRESS (If rural, give location): 1302 W. Lexington St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If over 1 year last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	11/11/1872	77	8	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Retired	New York City, N.Y.	U.S.A.

13. FATHER'S NAME: George Dawson

14. MOTHER'S MAIDEN NAME: Mrs Potter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
✓	—	

17. INFORMANT: John Delaney ADDRESS: 1302 W. Lexington St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cerdiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Cardio-vascular Disease — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1st, 1949 *to* July 30, 1949 *that I last saw the deceased alive on* July 30, 1949 *and that death occurred at* 12:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Glassman M. D.	2687 Mosher Ave	July 31 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	London Park	3801 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949

REGISTERED BY: [illegible]

25. FUNERAL DIRECTOR: John J. Cowan & Son ADDRESS: 90[illegible] Hollins St

VS 150

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): JULIA BRANCH

2. DATE OF DEATH: 7/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 206 Myrtle Av.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days: 4-2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 206 Myrtle Av.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Widowed	4/15/1873	76	3	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Domestic	Petersburg, Va.	U.S.A.

13. FATHER'S NAME: William Bird

14. MOTHER'S MAIDEN NAME: Adline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	NO	None

17. INFORMANT: Willie Branch (D) — ADDRESS: 206 Myrtle Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO

(B)
DUE TO

(C) Senile degeneration

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-14-, 1948 *to* 7-30-, 1949 *that I last saw the deceased alive on* 7-29, 1949. *and that death occurred at* 11:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. P. Cantbell M. D.	718 Dolphin St.	8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Burial	8/3/49	Lincoln Cemetery	Portsmouth, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Charles H. Griffin	512 Canal St.

VS 150

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G76819

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76819

Registered No.

1. NAME OF DECEASED (Type or Print) Max Pulverman

2. DATE OF DEATH July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

C. Length of stay in Baltimore 15 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4018 N Hilton Road 15-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	1859	90		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Philip Edward Pulverman

14. MOTHER'S MAIDEN NAME Yetta ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Philip E Pulverman ADDRESS St Paul Apts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) General & cerebral arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-31, 1949, *to* 7-31, 1949, *that I last saw the deceased alive on* 7-31, 1949, *and that death occurred at* 10:55 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.

23B. ADDRESS Sinai Hospital

23C. DATE SIGNED 7-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 2, 1949	Huntington W Va	

DATE RECEIVED BY LOCAL REGISTRAR AUG 1 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Sol Levinson & Bros ADDRESS 1126 W North Ave

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G76820 ✓ v1 G76820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Rose Martin

2. DATE OF DEATH 7-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jenkins Memorial Hospital

c. Length of stay in Baltimore 76 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 2708 Alameda Blvd.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md.
D. STREET ADDRESS (If rural, give location) 9-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F.	White.	Widowed.	Aug. 18, 1866	81 82	11	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Ireland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Philip Martin	Ann MARTIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	None	Rose M. Hoffman	2708 Alameda Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HYPOSTATIC PNEUMONIA

DUE TO

(B) ARTERIO SCLEROTIC GANGRENE - VASCULAR DISEASE

DUE TO

(C) MID THIGH AMPUTATION RT. LEG & LEFT LEG

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 1:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John W. Shaw M. D.	20 E. Lexington St.	7/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-3-49	New Cathedral	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams M.D.	Geo. L. Schwab	2101 Frederick Ave.

VS 150

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G76821 B.C.49-16505 BALTIMORE CITY HEALTH DEPARTMENT 760.0 G76821

BIRTH NO. Ca Counties

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) BABY BOY BAADER Craig Michael

2. DATE OF DEATH 8/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BON SECOURS HOSPITAL

C. Length of stay in Baltimore 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 23.
D. STREET ADDRESS (If rural, give location) 2174 Hollins St. 20-4.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M.	W.	Single	7/30/49			1	22	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore Md.	

13. FATHER'S NAME Norman Henry Baader

14. MOTHER'S MAIDEN NAME Virginia April Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Norman Baader	2174 Hollins St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) INTRACRANIAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 1 day 22 hrs.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 31, 1949, to Aug. 1, 1949 *that I last saw the deceased alive on* July 31, 1949, *and that death occurred at* 4:20 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul O. Francis M. D.	Bon Secours Hospital	8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-1-49	New Cathedral	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Geo. L. Schwab	2101 Frederick Ave.

VS 150

160a

D.O.A Medical Examiners case released to Hospital

G76822 — BALTIMORE CITY HEALTH DEPARTMENT — G76822

BIRTH NO. B.C. 48-1604 — **CERTIFICATE OF DEATH** — Registered No.

1. NAME OF DECEASED (Type or Print): Leroy Brown — 2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1013 Carlton St 16-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Child	Sept 21 1948		10			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Burrell	Elizabeth Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dehydration — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

(B) Diarrhea

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
For J. R. Davis, M.D.
William J. McClafferty M.D.
SIGN OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lowell Rhoads M. D.	JOHNS HOPKINS HOSPITAL	7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Mt Auburn	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Geo. B. Kelson	130 Pressman St

VS 150

1192

Medical Examiner to approve Certificates

G76823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

400 G76823 Registered No.

BIRTH NO. B C 49999

1. NAME OF DECEASED (Type or Print) ANTOINETTE HENRY

2. DATE OF DEATH July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore 5 Yrs. ~~Mos. Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1641 N. Lanvale St #17 16-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	Negro	Single	1944	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child	none	Maryland	U.S.A.

13. FATHER'S NAME Charles Henry

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no no		Mother	1641 N. Lanvale St #17

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic fever — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Backward failure; pulmonary Edema

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 6, 1949, to July 30, 1949, *that I last saw the deceased alive on* July 30, 1949, *and that death occurred at* 1:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles T. Henderson M. D.	University Hospital	7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/3/49	Mt Auburn	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Geo. H. Kelson	1303 Greenmount Ave

S 150

5-8-2

G76824

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76824

1. NAME OF DECEASED (Type or Print): Edward Miles

2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1552 Bruce St. 15-2

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 7/15/1899
9. AGE (In years last birthday): 50 — If under 1 year: Months, Days: 14 — If under 24 hours: Hours, Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Candy maker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Margaret Smith ADDRESS: 1352 Bruce St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

ANTECEDENT CAUSES

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from; natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: July 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/2/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949
REGISTRAR'S SIGNATURE: Twitty for Williams, M.D.
25. FUNERAL DIRECTOR: Geo. G. Kelson
ADDRESS: 1303 Pennsylvania Ave 94a

VS 151

G76825

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76825

1. NAME OF DECEASED (Type or Print) Sabatino Matani

2. DATE OF DEATH July 29 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 721 E. 23rd St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 721 E. 23rd St. 9-8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widowed	March 16 1862	87	4	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Castiglione Della Valle Teramo Italy	U.S.

13. FATHER'S NAME: Fermo Matani

14. MOTHER'S MAIDEN NAME: Carmela Recchia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Romeo Matani (Son)	721 E.23rd St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ARTERIOSCLEROSIS — Unknown

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JANUARY, 1945 *to* JULY 29, 1949 *that I last saw the deceased alive on* JULY 29, 1949, *and that death occurred at* 6.45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry W. Rosenthal M. D.	1907 Greenmount Ave, City	July 30-'49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	August 2nd 1949	(Holy Redeemer Cem)	4430 Belair Rd Balt. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, MD	Frank Dellabella	322 S. High St.

VS 150

940

676826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 676826

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DANIEL OTT

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chase
D. STREET ADDRESS (If rural, give location) Oliver Beach

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
Male	White	Single	3/21/1881	68	7	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer.

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Ott

14. MOTHER'S MAIDEN NAME Helen Weigand

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Catherine Ott ADDRESS 2342 Boulevard

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Arteriosclerotic cardiovascular disease.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. — 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE George A. Merrill M.D. — 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] — 23C. DATE SIGNED 7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Oak Lawn,	Eastern Bol. Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 1 1949 — REGISTRAR'S SIGNATURE Thurston Williams, M.D. — 25. FUNERAL DIRECTOR John J. Connelly ADDRESS Essex, Md.

93d

G76827

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 yr. 1

G76827

Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM H. WEATHERSTINE

2. DATE OF DEATH: 7/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 313 S. BOULDIN ST
C. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 26-10
D. STREET ADDRESS (If rural, give location): 313 S. BOULDIN ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
M	W	M	JULY 12, 1862	87		18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	BAKERY	BALTIMORE-MD	USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		MARIE GRANRUTH	6500 HUDSON ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CHRONIC MYOCARDITIS

DUE TO

(B) ARTERIOSCLEROSIS

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

SENILITY

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JULY 18, 1949, to JULY 30, 1949, *that I last saw the deceased alive on* JULY 30, 1949, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry J. Hourska M. D.	333 S. East Ave.	7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Loudon Pk.	Frederick Rd. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	John B. Connelly	Govt. Md

VS 150

93d

G76828

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

58

G76828
Registered No.

1. NAME OF DECEASED (Type or Print) PETRONELLA NAWROCKI

2. DATE OF DEATH July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland So. BALT. Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South. (General) BALTIMORE GEN.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 24, Md.
D. STREET ADDRESS (If rural, give location) 1601 PUMPHREY ST. 26-6

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 1898
9. AGE (In years last birthday) 51
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10B. KIND OF BUSINESS OR INDUSTRY at Home

11. BIRTHPLACE (State or foreign country) Poland.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Michael Nawrocki ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 10 Days.
DUE TO
(B) Post-operatively
DUE TO
(C) Empyema of Gall Bladder

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 30 July 49
19B. MAJOR FINDINGS OF OPERATION Empyema of Gall Bladder
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-16, 1949, to 30 July, 1949, that I last saw the deceased alive on 30 July, 1949, and that death occurred at 6:30 m., from the causes and on the date stated above.

23A. SIGNATURE John A. Sarno M. D.
23B. ADDRESS So. Baltimore Gen. Hosp
23C. DATE SIGNED 30 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug. 2/49
24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary
24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR AUG 1 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Fred W. Ozarzurki ADDRESS 1770 1930 Eastern Ave

VS 150

676829

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 676829

1. NAME OF DECEASED (Type or Print): MATILDA ANDERSON

2. DATE OF DEATH: July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 45 yrs

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1129 Abbott Court

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 hours: Hours	Min.
Female	White	Widow	Jan 3 1879	70	6	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Stockholm Sweden	

13. FATHER'S NAME: Unknown Cruckson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		none	Mrs Olive Schmeich	3626 Harford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *thereon and from the evidence obtained by said* (Autopsy, Inspection or Inquiry) *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Boyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Inter
24B. DATE: 8-4-49
24C. NAME OF CEMETERY OR CREMATORY: St Peters
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William P Dore
ADDRESS: 1219 Hollins

VS 151

93d

CERTIFICATE CORRECTED 8-1-49

G76830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443

Registered No. G76830

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sue Mueller

2. DATE OF DEATH: July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Med. Asst

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-14
D. STREET ADDRESS (If rural, give location): 1112 Roland Hgts Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Oct. 27 (1888)
9. AGE (In years last birthday): 61 (60)
If Under 1 Year: Months 9, Days 3
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): W. Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Crabbs
14. MOTHER'S MAIDEN NAME: Addie Blanks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ? Cerebral hemorrhage — Interval between onset and death: 24 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ? hypertensive cardiovascular disease + arteriosclerotic

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-30-, 1949 *to* 7-30-, 1949, *that I last saw the deceased alive on* 7-30-, 1949, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: William W. Dinterwich M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/3/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town, or county) (State): Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Milburn Co Dec
ADDRESS: 1217 E. Fayette St.

932

G76831

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1-60

G76831

Registered No.

1. NAME OF DECEASED (Type or Print) **Gerhard W. Reimers**

2. DATE OF DEATH **July 30/49**

3. PLACE OF DEATH: A. Baltimore City, Maryland **Baltimore, Md.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **3911 Edmondson Ave.**

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **3911 Edmondson Ave.** 20-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	**White**	**Married**	**Feb. 5, 1868**	**81**	5	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		**Germany**	

13. FATHER'S NAME **--------Reimers**

14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT **Wife** ADDRESS **Ave.** **Mrs. Margaret Reimers, 3911 Edmondson**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Myocardial failure** — INTERVAL BETWEEN ONSET AND DEATH: **24 Hrs.**

DUE TO

ANTECEDENT CAUSES

(B) **arteriosclerosis** — **7**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) **Diabetes Mellitus** — **Years**

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cardio-vascular - renal

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* **1947**, 19__, *to* **7-30**, 19**49** *that I last saw the deceased alive on* **7-30**, 19**49** *and that death occurred at* **5** p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Williams M. D.	**3921 Edmondson**	**8/1/49**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**Aug. 2/49**	**Oak Lawn, Eastern Ave. Essex, Md.**	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	**Harry A. Wright**	**4101 Edmondson Ave.**

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H.W. Schey C 61

G76832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 9 1 6 3

Registered No. G76832

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frank Jollie — N-949. ✓

2. DATE OF DEATH 7-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME HOSP.

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 4028 PENNINGTON AVE 25-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	MARRIED	FEB 2, 1893	56	5	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
BOILER MAKER	STANDARD OIL. CO.	GEORGIA.	USA.

13. FATHER'S NAME: THOMAS JOLLIE

14. MOTHER'S MAIDEN NAME: OZELA CAUSY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
YES	WW I	

17. INFORMANT: MRS AGNES C. JOLLIE — ADDRESS: 4028 PENNINGTON AVE -26

CAUSE OF DEATH

18.

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic pneumonia

DUE TO

(B) Acute Congestive Heart Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

2d-3rd° Burns - 10% Body

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Industrial

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Standard Oil Co., Boston St., Canton, Md. 26/6

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 21, 1949 ? p. m.

21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? Explosion of Oil-Still

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 31 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-2-49	BALTIMORE NATIONAL	FREDERICK RD.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: JOHN F. DENNY, Inc. — ADDRESS: 715 LIGHT ST

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-30 ✓

G76833 Gagliano G76833

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45

Registered No.

1. NAME OF DECEASED (Type or Print): Gagliano, John Joseph

2. DATE OF DEATH: July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The UNION Memorial Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 57 Burke Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W. Italian	Married.	April 12, 1925	24	3	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Black + Decker - Stock Clerk	Black + Decker	Maryland.	United States

13. FATHER'S NAME: Charles Gagliano, Sr.

14. MOTHER'S MAIDEN NAME: Rosa Mazzapelle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	World War II	216-12-3397	Mrs. Daisy Gagliano	57 Burke Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 23 days 12 hrs.

DUE TO

(B) Rupture of aneurysm circle Willis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 6, 1949, to July 30, 1949, *that I last saw the deceased alive on* _____, 1949, *and that death occurred at* 2:05 A.m.; *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles H. Watt, Jr., M.D.	Union Memorial Hospital	7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Moreland Park	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Leonard J. Leuck	5305 Harford Rd

VS 150

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G76834

BIRTH NO. B.C. 49-15114

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76834

1. NAME OF DECEASED (Type or Print): Baby Girl Sirbaugh

2. DATE OF DEATH: July 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 29 E. Fort Avenue 23-2

5. SEX: Fe.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 7/24/1949
9. AGE (In years last birthday) | If Under 1 Year: Months | Days: 2 | If Under 24 Hours: Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Alice Morva Baumann
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B) Impending Eclampsia in mother necessitated Cesarean section
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/24/ , 1949 *to* 7/26/ , 1949, *that I last saw the deceased alive on* 7/26/49 19 , *and that death occurred at* 6:50 AM., *from the causes and on the date stated above.*

23A. SIGNATURE: Vito L. Coppa M. D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: 7/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7-30-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949
REGISTRAR'S SIGNATURE: Penrington for Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck - 5305 ADDRESS: Harford Rd

VS 150

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BIRTH NO. 676835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 676835

1. NAME OF DECEASED (Type or Print) JOHN EDWARD TURNER

2. DATE OF DEATH 7/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. JOSEPH'S HOSP

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 22-44
D. STREET ADDRESS (If rural, give location) 3326 Bayonne Ave.

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 10/14/1891 | 9. AGE (In years last birthday) 57 | If Under 1 Year: Months 9, Days 16 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ? | 14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 216-05-3426 | 17. INFORMANT Hospital Records ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
DUE TO
ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/29, 1949, to 7/30, 1949 that I last saw the deceased alive on 7/30, 1949, and that death occurred at 6A m., from the causes and on the date stated above.

23A. SIGNATURE Thaddeus Zwinicki M. D. | 23B. ADDRESS St. Joseph's Hosp | 23C. DATE SIGNED 7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried | 24B. DATE 8/2/49 | 24C. NAME OF CEMETERY OR CREMATORY Moreland Park | 24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 1 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Leonard J. Luck - 5305 Harford Rd. ADDRESS

VS 150

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Dr. Harding
7[illegible]3805 Belair Rd.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

Registered No. G76836

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carolina K. (Carrie) Hagan

2. DATE OF DEATH: July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2423 Pelham Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2423 Pelham Avenue 8-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	married	Oct. 12, 1897	51	9	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Sigmund Kammermeyer	Theresa Brendel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mr. Bernard Hagan	2423 Pelham Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Hemorrhage	5 hours
	DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Ch. Hypertension	
	DUE TO	
	(C) Arteriosclerosis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 30, 1949, to July 30, 1949 *that I last saw the deceased alive on* July 30, 1949, *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	3805 Belair Rd.	Aug 1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-3-49	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Leonard J. Ruck,	5305 Harford Road.

VS 150

83a

G76837

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

491 Registered No. G76837

1. NAME OF DECEASED (Type or Print) Regina Hufsler

2. DATE OF DEATH July 29 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Garrison Nursing Home 2803 Garrison Blvd.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 154 N Milton Ave
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) 154 N Milton Ave 6-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Widow	Sept. 25 1869	80	10 / 4	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Baltimore, Md	U.S.A.

13. FATHER'S NAME Francis Schreiner

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Thomas W. Sampson	4402 Harrison Blvd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/7, 1949, *to* 7/29, 1949, *that I last saw the deceased alive on* 7/29, 1949, *and that death occurred at* 7:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert G. Retter M. D.	3408 Windsor Ave.	7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Holy Redeemer	Balto.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	John C. Moran	3000 Baltimore St

VS 150

107

~~6838~~ E931 G76838

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Louis Kennel — N-981.0

2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): John Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY: 1746 E. Federal Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1746 E. Federal Street — 8-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Feb. 12, 1914	35	5 / 17	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rec. Clerk	Int. Bedding Co.	A. A. Co., Md.	

13. FATHER'S NAME: Louis Kennel

14. MOTHER'S MAIDEN NAME: Mary Gunther

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes		Ruth C. Kennel	1746 E. Federal

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heat Prostration — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CERTIFICATION APPROVED BY William H. Kammer, M.D. per H. J. McCafferty M. D. CHIEF OR ASST. MEDICAL EXAMINER

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertension

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Home	1746 E. Federal St.

21D. TIME OF INJURY (Month) - (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 29, 1949 a.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Excessive Heat

22. *I hereby certify that I attended the deceased from* 7/29 19~~49~~ *to* 7/29 19~~49~~, *that I last saw the deceased alive on* 7/29 19~~49~~, *and that death occurred at* 2:~~50~~ *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. Hess M.D. M. D.	1922 E. Fort Ave	8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	National	Federick Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	Clarence F. Hoffmann	1639 Broadway

VS 150

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G76839

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76839

1. NAME OF DECEASED (Type or Print): Annie C. Huggins

2. DATE OF DEATH: 31 July 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: 76 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3422 Guilford Terrace 12-2

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1873 3/17/47
9. AGE (In years last birthday): 75 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lan Lady
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Thomas J. Huggins.
14. MOTHER'S MAIDEN NAME: Jane C. Magraw
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: James Huggins (Nephew) ADDRESS: 3818 Greenmount Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Calcified aortic stenosis, severe

DUE TO

(C) arteriosclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY DR R.B. Mc Fadden

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (CORONER OR ASSISTANT MEDICAL EXAMINER, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/3/49, 1949 to 2/3/49, 1949, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Charles N. Watt, Jr. M. D.
23B. ADDRESS: Union Memorial Hosp.
23C. DATE SIGNED: 2/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug-3/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmt-
24D. LOCATION (City, town, or county) (State): Bald Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949
REGISTRAR'S SIGNATURE: Lentington Williams, Md
25. FUNERAL DIRECTOR: Stewart Memorial Co.
ADDRESS: Balto.

VS 150

92a

BIRTH NO. 76840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 76840

1. NAME OF DECEASED (Type or Print): Emma Barnitz Myers (Mrs J. Ross) | 2. DATE OF DEATH: 7 | 31 | 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 900 W University (Lorm)
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 900 W. University Pkwy
c. Length of stay in Baltimore: 54yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-14
D. STREET ADDRESS (If rural, give location): 900 W. University Pkwy

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	married	Nov 19, 1867	81	8	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	none	Pennsylvania	U.S.A.

13. FATHER'S NAME: Albert M. Barnitz
14. MOTHER'S MAIDEN NAME: Martha Wirt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	—	J. Ross Myers, Jr	6011 Mossway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 16d.
DUE TO
(B) Arteriosclerotic heart d — 5 yrs.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 15, 1949 *to* July 31, 1949 *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 9:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Ross Myers M. D.	Towson 4, Md	7/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	July 7 '49	Druid Ridge	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Hattie Lee Williams, M.D.	Stevenson Morris & Ball	

VS 150

931

G76841

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3 31 ✓

G76841

Registered No.

1. NAME OF DECEASED (Type or Print): Sister Catherine Kennedy

2. DATE OF DEATH: 7-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6420 Reisterstown Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Seton Institute
c. Length of stay in Baltimore: 34 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6420 Reisterstown Road 28-1

5. SEX: F
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: 9-7-1879
9. AGE (In years last birthday): 69 — If Under 1 Year: Months 10, Days 24 — If Under 24 Hours: Hours 12, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sister of Charity
10B. KIND OF BUSINESS OR INDUSTRY: Religious
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Patrick Kennedy
14. MOTHER'S MAIDEN NAME: Sarah Donlan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS: The Seton Institute - Balto. 15 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rt Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 Mths
DUE TO
(B) Arterio-sclerosis
DUE TO
(C) Diabetus mellitus — 10 yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1939 *to* July 31, 1949 *that I last saw the deceased alive on* 7/31, 1949 *and that death occurred at* 11:50 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Dagmar L. Glazier M. D.
23B. ADDRESS: 33 Woodmont
23C. DATE SIGNED: 7/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/2/49
24C. NAME OF CEMETERY OR CREMATORY: Seton
24D. LOCATION (City, town, or county) (State): Seton Institute

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Stewart Mortuary Company
ADDRESS: Balto

VS 150

61

G76842

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76842

1. NAME OF DECEASED (Type or Print): William Geisen N 803

2. DATE OF DEATH: July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes
C. Length of stay in Baltimore: 14 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 137 N. Monroe St. 20-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	Nov. 8, 1890	58	8	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machine operator	Lumber Mill	Maryland	U. S. A.

13. FATHER'S NAME: John H. Geisen

14. MOTHER'S MAIDEN NAME: Mary A. Barrett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-16-0067

17. INFORMANT: John H. Geisen — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fractures of Skull c
DUE TO
(B) Cerebral Contusions

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Washington Blvd. and Elkridge Rd. 63-00

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-16-49 11 P. m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Elkridge, Md. Ped. struck by an auto.

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L. Mayer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 7/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 8/2/49

24C. NAME OF CEMETERY OR CREMATORY: St. Marys

24D. LOCATION (City, town, or county) (State): Elchester, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Easton Sons — ADDRESS: Catonsville Md.

170c

VS 151

G76843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76843

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Nicholas Gregola (Conugale)

2. DATE OF DEATH July 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, last residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

D. STREET ADDRESS (If rural, give location) 419 Vincent St. 19-1

C. Length of stay in Baltimore Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widower	1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Italy

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED July 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Aug. 2/1949

24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem

24D. LOCATION (City, town, or county) (State) Edmondson ave ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR AUG 1 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John M. Weber

VS 151

937

G76844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76844

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES F. W. BELL

2. DATE OF DEATH: August 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): New Howard Hotel

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Allegany
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cumberland
D. STREET ADDRESS (If rural, give location): 512 BEall Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	6/18/1892	57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chief Team Dispacher	B.O.R.R.	Grafton W. Va.	Usa

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles F. Bell	Rose Beyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	********	*******	Mrs. Elizabeth Bell	(Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Jug. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl V. Royer M.D.		8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	AUG. 4/49	ROSE HILL CEMETERY	Cumberland Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1 1949	Huntington Williams, M.D.	C. F. Wiegand & Son	300 Centre Pl.

VS 151

94a

6845

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59 ✓ Registered No. G76845

1. NAME OF DECEASED (Type or Print) **Fannie Pratt**

2. DATE OF DEATH **July 31. 1949**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **Balto.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **1052 Pennsylvania Ave.**

c. Length of stay in Baltimore **3 Mos.** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **1052 Pennsylvania Ave.** 17-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Female	Col.	Widow	Sept. 11. 1881	67	10	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Essex Co. Va.**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Williams Rankin**

14. MOTHER'S MAIDEN NAME **Unkown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT **Irne Pratt** ADDRESS **1052 Pennsylvania Ave.**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Chronic Interstitial Nephritis** — INTERVAL BETWEEN ONSET AND DEATH **History Indefinite**

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 22, 1949, to July 31, 1949 *that I last saw the deceased alive on* July 31, 1949, *and that death occurred at* 9:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE **R. Garland Whitsell** M. D. | 23B. ADDRESS **1334 Druid Hill Ave** | 23C. DATE SIGNED **Aug. 1, 1949**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 2 1949	Essex Co. Vam.	Essex CO. Va.

DATE RECEIVED BY LOCAL REGISTRAR **AUG 1 1949** | REGISTRAR'S SIGNATURE **Cunningham Williams, M.D.**

25. FUNERAL DIRECTOR **Elroy O. Wilson** ADDRESS **1000 Brantly Ave**

VS 150

131a

G76846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

174

G76846

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY E BARNES

2. DATE OF DEATH JULY 28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1114 E 36th St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1114 E 36TH ST.

c. Length of stay in Baltimore 3 1/2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1114 E 36TH ST 9-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	MARRIED	Jan 9-1872	77	6 / 19	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE	AT HOME	MARYLAND	U.S.

13. FATHER'S NAME COLUMBUS LINDSAY

14. MOTHER'S MAIDEN NAME MARY BLOOM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	No	NONE	MARGARET WALTERS 1114 E 36TH ST. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Pneumonia (Hypostatic Congestion) — INTERVAL BETWEEN ONSET AND DEATH 2 days

DUE TO

(B) Carcinoma of uterus

DUE TO

(C) Hypertension Anemia Arteriosclerosis Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0	0	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
0	0	0

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
0 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	0

22. *I hereby certify that I attended the deceased from* Nov 20 1948 *to* July 28, 1949, *that I last saw the deceased alive on* July 28 1949, *and that death occurred at* 7:45 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles A. Anderson M. D.	3001 Sharon Drive Baltimore (13)	7/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7/31/49	PIPE CREEK CEM	UNIONTOWN ROAD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 2 1949	Huntington Williams, M.D.	P.D. HARTZLER & SONS NEW WINDSOR & UNION BRIDGE MARYLAND

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 Registered No. 68-47

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Katy McCraw

2. DATE OF DEATH: 7-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
c. Length of stay in Baltimore: 24 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 503 Cherry Hill Rd. 2-5-32

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Negro	Wid.	July 20, 1886	63		10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Calvin Jennings
14. MOTHER'S MAIDEN NAME: Amanda Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage with Intraventrical and subarachnoid Bleeding
DUE TO
(B) Hypertensive Arteriosclerotic Cardio Vascular disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Pyelonephritis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-29-49, 19 49 *to* 7-30, 19 49 *that I last saw the deceased alive on* 7-30, 19 49 *and that death occurred at* 10:30 m. P *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rozier M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 3-1949	Mt Calvary	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams, M.D.	V. E. Brooks	1463 N. Carey St.

VS 150

93d

BIRTH NO. 76848

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76848
Registered No.

1. NAME OF DECEASED (Type or Print): ADAM P. QUICK

2. DATE OF DEATH: 8/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2235 E Oliver St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 46 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 2235 E. Oliver St. 8-4

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 7th, 1884
9. AGE (In years last birthday): 65 — If under 1 year: Months 1, Days 24, Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator (retired)
10B. KIND OF BUSINESS OR INDUSTRY: Balto. Transit Co.
11. BIRTHPLACE (State or foreign country): Baltimore County, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Peter Quick
14. MOTHER'S MAIDEN NAME: Margaret Trautner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 213-10-1459
17. INFORMANT: Mrs. Adam P. Quick — ADDRESS: 2235 E. Oliver St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial insufficiency
DUE TO
(B) Lung Abscess, left lung
DUE TO
(C) Diabetes

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Tuberculosis, pulmonary; not Determined

INTERVAL BETWEEN ONSET AND DEATH
(A) 3 days
(B) Unknown 2-3 months
(C) Unknown

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 July, 1949 *to* 1 Aug, 1949, *that I last saw the deceased alive on* 1 Aug, 1949, *and that death occurred at* 11A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Howard Johnson, M. D.
23B. ADDRESS: 1513 N. Milton Ave
23C. DATE SIGNED: 1 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 8/4/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: Lassahn Funeral Home — ADDRESS: 7401 Belair Rd.

VS 150

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BIRTH NO. 76849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76849

1. NAME OF DECEASED (Type or Print): LILLIAM M. HUBER

2. DATE OF DEATH: 8/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4301 Springwood Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 4301 Springwood Ave. 26-1

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Feb. 22, 1870
9. AGE (In years last birthday): 79 — If Under 1 Year: Months 5, Days 9 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Linzey
14. MOTHER'S MAIDEN NAME: Sarah Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Samuel W. Hiss — ADDRESS: 4301 Springwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO
(B) Parkinson's Disease, Diabetes mellitus
DUE TO
(C) Arteriosclerotic C.V.D.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 Days

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 31, 1949, *to* Aug 1, 1949 *that I last saw the deceased alive on* July 31, 1949, *and that death occurred at* 7:40 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. Harvey Shaw M.D. M. D.
23B. ADDRESS: 4218 Liberty Rd.
23C. DATE SIGNED: 8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 8/4/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lassahn Funeral Hom — ADDRESS: 7401 Belair Rd.

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G76850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76850

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Beulah V. Moody

2. DATE OF DEATH July 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 110 N. Carrollton Ave.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 110 N. Carrollton Ave. 18-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Single	Nov. 15, 1894	54	8 / 15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME Morris Moody

14. MOTHER'S MAIDEN NAME Rhoda Michels

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Lucy Holmes Watkins ADDRESS 110 N. Carrollton Ave

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pneumonia, Total — INTERVAL BETWEEN ONSET AND DEATH 15 Days

DUE TO

(B)

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 49 *to* July 30, 49, *that I last saw the deceased alive on* July 24, 49 *and that death occurred at* 7:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Wm Cooper M. D.

23B. ADDRESS 313 Cerry St

23C. DATE SIGNED 8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8-2-49

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY REGISTRAR AUG 2 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Mrs Frances A. Hemsley ADDRESS 578 W. Biddle

VS 150

108

G76851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

539 / G76851

BIRTH NO. G76851 Registered No.

1. NAME OF DECEASED (Type or Print): Helen Divine Morsell

2. DATE OF DEATH: AUG - 1 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Calvert
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sunderland
D. STREET ADDRESS (If rural, give location):

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 7-16-49
9. AGE (In years last birthday): If Under 1 Year: Months / Days: 15 / If Under 24 Hours: Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Clifton Ray Morsell

14. MOTHER'S MAIDEN NAME: Mary E. Gross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Trachea-esoph. fistula — INTERVAL BETWEEN ONSET AND DEATH: 15 days
DUE TO
(B) mediastenitis — 6 days
DUE TO Break down
(C) Breakdown anastomosis — 6 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-25, 1949 *to* 8-1, 1949 *that I last saw the deceased alive on* 8-1, 1949, *and that death occurred at* 4:50 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm H. Zinkham M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/2/49
24C. NAME OF CEMETERY OR CREMATORY: Edmondson
24D. LOCATION (City, town, or county) (State): Calvert County

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949
REGISTRAR'S SIGNATURE: Tunstall Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Pinkey Isaac - Calvert County

VS 150

114e

6852 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 G76852 Registered No.

1. NAME OF DECEASED (Type or Print): Mary V. Mullikin

2. DATE OF DEATH: July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3318 Egerton Road
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none
c. Length of stay in Baltimore: ~~70~~ 23 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3318 Egerton Road 15-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	single	Dec. 19, 1878	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Anne Arundel Co.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Clay Mullikin
14. MOTHER'S MAIDEN NAME: Richarda S. Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: H. Clay Mullikin - 3318 Egerton Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Paralysis Agitans (Familial) — INTERVAL BETWEEN ONSET AND DEATH: 10 years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1943, *to* July 30, 1949, *that I last saw the deceased alive on* July 29, 1949, *and that death occurred at* 1.35 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. Grafton Hesperger M. D.
23B. ADDRESS: Medical Arts Bldg.
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 8/2/49
24C. NAME OF CEMETERY OR CREMATORY: Trinity Meth. Church
24D. LOCATION (City, town, or county) (State): Patuxent, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: John O. Mitchell & Sons, Inc.--1900 Eutaw Pl.
Wm B Mitchell

VS 150

87c

G76853

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76853
Registered No.

1. NAME OF DECEASED (Type or Print) MARIAH FERGERSON

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 1919 Druid Hill Avenue 14-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Widow	June 2, 1885	64	1 / 27	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housemaid
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balt. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James D. Evans
14. MOTHER'S MAIDEN NAME Dianna Powell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Miss Anna B. Evans ADDRESS 1919 Druid Hill Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or compilication which caused death.)
(A) Cardiovascular-renal disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED July 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 2 1949	Mt. Auburn	Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949
REGISTRAR'S SIGNATURE: Initialing for Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS 1319 Druid Hill Ave

VS 151

768:54 CERTIFICATE CORRECTED 8-9-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 · G768:54 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Marian Powell

2. DATE OF DEATH 7-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 531 N. Strieker St 19-1

5. SEX female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH feb 24 1901 | 9. AGE (In years last birthday) 48 | If Under 1 Year: Months 5 Days 4 | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Middlesex Co. Va. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Harvey Henry

14. MOTHER'S MAIDEN NAME Martha Burke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No. | 16. SOCIAL SECURITY NO.

17. INFORMANT Mr. Armstead Powell - N. Strieker St ADDRESS 531

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Nephrosclerosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Generalized Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-19, 1949, to 7-28-49, *that I last saw the deceased alive on* 7-28 1949 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED 7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug. 2 1949 | 24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk. | 24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 2 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS Holland Funeral Home 1631 Druid Hill Ave.

VS 150

131a

G768:5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G768:5

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): SARAH McGILL

2. DATE OF DEATH: July 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: 65 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1905 Etting Street 14-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Widow	Feb. 9 1871	78	5	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Calvert Co. Md.	U.S.A.

13. FATHER'S NAME: Joshua Worrell

14. MOTHER'S MAIDEN NAME: Lucy Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		Mrs. Alberta C. Hall	515 Hooker St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-

DUE TO Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: William J. McCafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 7-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Mt. Auburn	Baltimore, Md.

DATE RECEIVED BY REGISTRAR: AUG 2 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR | ADDRESS: Holland Funeral Home 1691 Druid Hill Ave. 93d

VS 151

G768856

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G768856 Registered No.

1. NAME OF DECEASED (Type or Print): Bessie Montague

2. DATE OF DEATH: July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1307 Harlem Ave. 16-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Single	1887	62 mp		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maid
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Prince George's Co. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Georgianna Tate
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lucille Jones ADDRESS: 1307 Harlem ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C. V. disease
DUE TO
(B) Obesity
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: C. F. Salminski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: July 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 3, 1949	Mt. Auburn Cemetery	Cedar Lee, Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Halstead ADDRESS: 918 Druid Hill Ave

VS 151

93d

G768:57

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#43

Registered No. G768:57

1. NAME OF DECEASED (Type or Print): PHILIP GENTILE

2. DATE OF DEATH: 7/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital
c. Length of stay in Baltimore: 40 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore-13.
D. STREET ADDRESS (If rural, give location): 2813 E. Chase St. 8-3

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: Unknown 1874
9. AGE (In years last birthday): 75
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Mario Gentile

14. MOTHER'S MAIDEN NAME: Christina Enzaloni

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Margaret Kurrupes ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive CVD Disease 6 yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-21- , 1949 *to* 7-30 , 1949 *that I last saw the deceased alive on* 7-30 , 1949 *and that death occurred at* 10:20 p m, *from the causes and on the date stated above.*

23A. SIGNATURE: Robert E. Eurich M. D.
23B. ADDRESS: Church Home Hosp.
23C. DATE SIGNED: 7/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. 3/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State): Belair Rd Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Miller ADDRESS: 2334 Jefferson St.

VS 150

93'd

G768:8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

7 31

G768:8

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Herman Springer

2. DATE OF DEATH: July 30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 718 N. Patterson Pk. Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 7-3
D. STREET ADDRESS (If rural, give location): 718 N. Patterson Pk. Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Dec. 26-1877	71	7	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Balto.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Valentine Springer

14. MOTHER'S MAIDEN NAME: Catherine Schrieber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Lilly S. Springer — ADDRESS: 718 N. Patterson Pk. Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Paget's Disease of bone — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 4, 1948 *to* Aug 1, 1949 *that I last saw the deceased alive on* July 31, 1949, *and that death occurred at* 7 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Joseph J Pokorny M. D.

23B. ADDRESS: 2200 E Madison St

23C. DATE SIGNED: 8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Aug. 3-49

24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John A. Muller

ADDRESS: 2334 Jefferson St.

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VS 150

G768:9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 v° 1 G768:9 Registered No.

G768:9

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Theophilos H. Sorandes

2. DATE OF DEATH 7-30-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 906 W. 38th St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. 32 years Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 906 W. 38th Street. 13-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	9-6-1885	63	10	24

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Auto. Mechanic	Self Employed	Armenia	U S A

13. FATHER'S NAME: Haralambos Sorandes

14. MOTHER'S MAIDEN NAME: Lucy ---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Mrs. Jane H. Sorandes ADDRESS: 906 W. 38th Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Heart Disease — Interval between onset and death: 1 year
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
Robert B. McFadden M.D.		9-31-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	August 2, 1949	Lorraine Park	Baltimore Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 2 1949	Huntington Williams, M.D.	Burgee Funeral Home 3631 Falls Road

VS 151.

94a

G76860

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 0 G76860

Registered No.

1. NAME OF DECEASED (Type or Print): SARAH E. LYNCH

2. DATE OF DEATH: Aug. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 761 Melville Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 761 Melville Ave. 9-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widow	June 12, 1865	84	1	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	

13. FATHER'S NAME: Joseph Parsons

14. MOTHER'S MAIDEN NAME: Percilla Hardester

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Richard Lynch	761 Melville Ave.

MEDICAL CERTIFICATION

18.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) ARTERIOSCLEROSIS, HYPERTENSION	10 years
	DUE TO	
ANTECEDENT CAUSES	(B) HYPERTENSION,	10 YEARS
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C) HYPERTENSIVE HEART DISEASE	10 YEARS
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NONE		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 1, 1949, *to* August 1, 1949, *that I last saw the deceased alive on* July 31, 1949, *and that death occurred at* 3:57A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Randolph H. Spitzberg M. D.	5010 Denmore Ave	Aug 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/4/49	Mt. Olivet	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams, M.D.	William Cook, Inc.,	1217 St. Paul St.

VS 150

93d

CERTIFICATE CORRECTED 8-16-49 ✓

G76861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

585

G76861

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph B. Hitchens

2. DATE OF DEATH 31 July 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore (68) 67 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.

D. STREET ADDRESS (If rural, give location) 2637 Guilford Ave 12-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	9 Feb (~~1881~~) 1882	(67) 67	5	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lathey Contractor	—	Virginia	U.S.

13. FATHER'S NAME Eli Hitchens

14. MOTHER'S MAIDEN NAME ~~Mary E.~~ Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Mary E. Hitchens (wife)	Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia — INTERVAL BETWEEN ONSET AND DEATH: agg. 2 days

DUE TO

(B) cholangitis

DUE TO

(C) cholecystitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
30 July '49	Empyema of gall bladder	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 30 July, 1949, *to* 31 July, 1949, *that I last saw the deceased alive on* 31 July, 1949, *and that death occurred at* 12⁰⁰ P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Green, M.D.	Union Memorial Hosp.	8-1-49

24A. BURIAL, CREMATION OR REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
Burial	Aug 3/1949	Lorraine	Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Thurlington Williams, M.D.	Harry P. Armacost	4204 Edgewood Ave

VS 150

147a

76862

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160 G76862 Registered No.

1. NAME OF DECEASED (Type or Print): VIRGINIA GREY

2. DATE OF DEATH: 8/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pikesville
D. STREET ADDRESS (If rural, give location): 1729 Reisterstown Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	single	7/31/49	new born	0	0	23	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Pikesville Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: not known
14. MOTHER'S MAIDEN NAME: Mary Grey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.

17. INFORMANT: mother ADDRESS: 1729 Reisterstown Road

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 23 hours
DUE TO
(B) birth trauma — 23 hours
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/31, 1949 *to* 8/1, 1949, *that I last saw the deceased alive on* 8/1, 1949, *and that death occurred at* 1:05 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: William V. Gross, Jr. M. D. | 23B. ADDRESS: Union Memorial Hospital | 23C. DATE SIGNED: 8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Aug 2/49 | 24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge | 24D. LOCATION (City, town, or county) (State): Pikesville, Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949 | REGISTRAR'S SIGNATURE: Kensington Williams, M.D. | 25. FUNERAL DIRECTOR: Loring Byrn | ADDRESS: 500 N. Howard

VS 150

160a

G76863

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76863

1. NAME OF DECEASED (Type or Print): Maggie Whitehead

2. DATE OF DEATH: 31 July 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18
D. STREET ADDRESS (If rural, give location): 1431 W. 36th St. 12-8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	1898 Feb 4	51	5 / 24	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tube Bender	Schmitt Rubber Co	Va	US

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	213-05-3988	Daughter	same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO

(B) Hypertensive cardiovascular disease

DUE TO

(C) Arteriosclerosis, general.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
[illegible] M.D.
CORONER OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY occur? (Give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	Patient dead on arrival at UMH Acc. Pm. 31 July 49

22. *I hereby certify that I attended the deceased from* Patient dead on arrival, 19__, to _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 12 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles H. Watt Jr., M. D.	Union Memorial Hospital	7/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 3, 1949	St Mary's	Hampden

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams, M.D.	Paul E. Lehmann	3600 W. Belvedere Ave

S-150

932

76864

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3 1 G76864

Registered No.

1. NAME OF DECEASED (Type or Print): MARGARET MARY JONES Mrs.

2. DATE OF DEATH: 7/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2101 W. Gold Spring Lane

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elkins Nursing Home

C. Length of stay in Baltimore: 60 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1902 N. Castle St. 8-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widower	Feb 16th 1877	72	5 / 14	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		New York	

13. FATHER'S NAME: Nathan Oliver

14. MOTHER'S MAIDEN NAME: Augusta Hughes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mildred McLoready	2117 Eutaw St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of, dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 8 HRS.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) HYPERTENSION — 10 YRS

DUE TO

(C) OBESITY — 10 YRS.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* FEB 15, 1946 *to* JULY 30, 1949, *that I last saw the deceased alive on* 7/30, 1949, *and that death occurred at* 2:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas R. Kleiman, M. D.	3803 Edmondson Ave	8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 2nd 1949	Baltohem	East North Ave Ext

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams, M.D.	Lee D. Leach	1703 N. Patterson Park Ave

VS 150

83a

676865

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 97-0 676865 Registered No.

1. NAME OF DECEASED (Type or Print): Mrs Clara Day — N-968.0

2. DATE OF DEATH: 7-31-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals

c. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
b. STREET ADDRESS (If rural, give location): 1263 S. Potomac St 1-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	married	6-20-14	35	1	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Baltimore Md.	U.S.

13. FATHER'S NAME: Stanley Kruszynski

14. MOTHER'S MAIDEN NAME: Frances Rosinska

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Stanley Day — ADDRESS: 1262 Potomac St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia

DUE TO

(B) Illuminating Gas

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 1

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	1263 S Potomac St

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
7 31 49 7P m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Gas at Home

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
Robert B McFadden M.D.		8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 3/49	St. Stanislaus	Dundalk Ave Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams, M.D.	John J. Duda	2829 Hudson St.

VS 151

163-H

76866

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76866

1. NAME OF DECEASED (Type or Print): RICHARD H. GREGORY

2. DATE OF DEATH: July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2812 Clifton Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1849 W. Mulberry St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	Oct. 9, 1896	52 yrs.	9	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Gregory	Josephine Etzel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	World War #1		Mrs. Mary I. Gregory	1849 W. Mulberry St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 da

DUE TO

(B) Coronary Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/28, 1949 *to* 7/31, 1949 *that I last saw the deceased alive on* 7/31, 1949 *and that death occurred at* 5:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph G Laycock M. D.	629 Washington Blvd	8/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/4/49	Balto. National Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

94a

G76857 | BALTIMORE CITY HEALTH DEPARTMENT | No. 1 G76857

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ANNIE LAURA BLEY

2. DATE OF DEATH: Aug. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2312 Poplar Grove St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2312 Poplar Grove St. 15-47

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	widow	Aug. 10, 1866	82 yrs.	11	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Baltimore, Md.	

13. FATHER'S NAME: Daniel Erek

14. MOTHER'S MAIDEN NAME: - Claukson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Frank Beacham — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Sclerosis

DUE TO

(B) Arteriosclerosis

DUE TO And Senility

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Sept 1947 *to* Aug 1st 1949, *that I last saw the deceased alive on* Aug 1, 1949, *and that death occurred at* 7 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 20 33 Woodland

23C. DATE SIGNED: 8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/1/49	Lorraine Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: M. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150

940

G76868

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76868

1. NAME OF DECEASED (Type or Print): HELEN MacCARTHY

2. DATE OF DEATH: July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shriner Nursing Home, 3520 Hilton Rd.
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3520 Hilton Rd. 15-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	April 14, 1868	81 yrs.	3 / 17	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-	-	Baltimore, Md.	

13. FATHER'S NAME: Florence Thomas MacCarthy

14. MOTHER'S MAIDEN NAME: Anne White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. Howard MacCarthy	100 W. University Pkwy.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma - gall bladder and liver (suspected) — INTERVAL BETWEEN ONSET AND DEATH: about 1 yr.

DUE TO

(B)

DUE TO

(C) Arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 25, 1949 *to* July 31, 1949, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter S. Tebbett, M. D.	222 Garrison Blvd	Aug 1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Woodlawn Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

46 f 1

BIRTH NO. 6768.9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6768.9

1. NAME OF DECEASED (Type or Print) DAVID T. WEBSTER

2. DATE OF DEATH July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1514 West Fayette St. 19-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Widowed	Aug. 22, 1872	76 yrs.	11	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Steamfitter-rtd		Carroll Co., Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Luther Webster	Mary Bloom

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		Mrs. E. Leish - 2117 Gwynn Oak Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L. Mayer M.D.		August 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949		WM. J. TICKNER & SONS	Balto., Md.

93d

G768.0

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G768.0

1. NAME OF DECEASED (Type or Print): MARY DORA Kaupp

2. DATE OF DEATH: 1 August 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. General (DOR) Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 2629 Edmondson Ave. 20-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	divorced	Jan. 20, 1885	64 yrs.	6	12		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Balto., Md.	

13. FATHER'S NAME: John Popp

14. MOTHER'S MAIDEN NAME: Laura Catherine Lambright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Charles J. Popp ADDRESS: 75 S. Morley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH. (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED: 1Aug.1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/4/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 151

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G76871.

G-68232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76871

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Florence Gross Bates

2. DATE OF DEATH: 7-30-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals 4940 Eastern Av.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): B.C.H.Infirmary 26-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Wid.	April 26,1897	52	3	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Domestic	Balto. Md.	U.S.A.

13. FATHER'S NAME: Benj.

14. MOTHER'S MAIDEN NAME: Ella

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	No	None

17. INFORMANT: B.C.H.Records ADDRESS: 4940 Eastern Av.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis

DUE TO

(B) Hypertensive Arteriosclerotic Heart disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/14/43, 19__, *to* 7/30/49, 19__, *that I last saw the deceased alive on* July 30, 19 49 *and that death occurred at* 4:15A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. S. Brown M. D.	4940 Eastern Av	7/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/2/49	Mt. Auburn	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams, M.D.	Chas. H. Hoffman & Sons	512 Cathedral St.

VS 150

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(over)

G76872

BIRTH NO. G76872

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76872

1. NAME OF DECEASED (Type or Print) ZACK WOOD

2. DATE OF DEATH July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE ~~Md.~~ Virginia
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Whitestone
D. STREET ADDRESS (If rural, give location) 1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
m	col	SEP.	3/7/89	60	4 / 24	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
deckhand	Seafarer	Va.	USA

13. FATHER'S NAME William Wood

14. MOTHER'S MAIDEN NAME Jane Ball

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Unknown	228-10-8039	Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of stomach with carcinomatosis of peritoneum — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN

DUE TO

(B) Pulmonary embolism — SEVERAL HOURS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* July 12, 1949, *to* July 31, 1949, *that I last saw the deceased alive on* July 31, 1949 *and that death occurred at* 3:50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson John L. Wilson, Medical Director M.D.	US Marine Hospital, Balto, Md.	8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/3/49	White Stone	White Stone Virginia

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 2 1949	Huntington Williams, M.D.	Geo. G. Kelson 1303 Pressman St.

VS 150

461

G76873

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

31 G76873 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs Mary Rossiter

2. DATE OF DEATH 7-31-49

3. PLACE OF DEATH: a Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1700 W Fayette St. 19-2

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklyn Square Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Widowed	Jan. 1, 1876	73	6	30		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? —
13. FATHER'S NAME Edward Clewel
14. MOTHER'S MAIDEN NAME Margaret Victor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT ADDRESS Mrs. T. M. Griffin 1700 W. Fayette St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(B) Arterio sclerosis Severely Ed — Unknown
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE Robert B. McFadden M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED 8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8-3-49
24C. NAME OF CEMETERY OR CREMATORY Holly Creed
24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 2 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS George A. Fraley Fulton Ave & Fayette St.

VS 151

532

6874

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76874

1. NAME OF DECEASED (Type or Print) Ebling, Gilbert William

2. DATE OF DEATH August 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 10 E. Fort Ave. 23-V

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	2/6/09	40 yrs	5	26

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Policeman-Balto. C.		Baltimore, Md.	

13. FATHER'S NAME William H. E. Ebling

14. MOTHER'S MAIDEN NAME Elizabeth Schmadt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Ruth M. E. Ebling	10 E. Fort Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aplastic Anemia — INTERVAL BETWEEN ONSET AND DEATH: 13 days

DUE TO

ANTECEDENT CAUSES

(B) Ca

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cellulitis, right leg — 1 8 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/21/49	Cellulitis right leg.	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 17, 1949, *to* Aug. 1, 1949, *that I last saw the deceased alive on* Aug 1, 1949, *and that death occurred at* 8 [illegible] m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Eugene F. Lee, M. D.	St Joseph's Hospital	8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 4 1949	Holy Cross	Anne Arundel Co

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 7 1949	Thurlington Williams, M.D.	C. Howard Evans	1400 Gilmore St

VS 150

152

G76875

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

075 G76875 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK Harris

2. DATE OF DEATH 7-28-49

3. PLACE OF DEATH: Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp.

3c. Length of stay in Baltimore Yrs. Mos. Days 16 2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1018 Calhoun St

5. SEX M | 6. COLOR OR RACE C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Dec. 25 1900 | 9. AGE (In years last birthday) 49 Yrs | If Under 1 Year: Months 7, Days 3 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | 10B. KIND OF BUSINESS OR INDUSTRY Tackle Inst.

11. BIRTHPLACE (State or foreign country) Penn. | 12. CITIZEN OF WHAT COUNTRY? Balto

13. FATHER'S NAME G. H. Harris

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 701-12-5302

17. INFORMANT Bessie Harris | ADDRESS 2340 - 8th St Balto

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Syphilitic Meningo-Encephalitis

DUE TO

(B) Congenital Heart Disease - Probable Interventricular Septal Defect

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1 1949 to July 28, 1949, *that I last saw the deceased alive on* 7-28, 1949, *and that death occurred at* 10 30/A m., *from the causes and on the date stated above.*

23A. SIGNATURE R. H. Sanders Jr M. D. | 23B. ADDRESS Univ. Hosp. | 23C. DATE SIGNED 9-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Mt Auburn Cemtry | 24B. DATE 8-2-1949 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemtry | 24D. LOCATION (City, town, or county) (State) Balto.

DATE RECEIVED BY LOCAL REGISTRAR AUG 2 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Walter B. Sprigg | ADDRESS 139 W. Hamburg St.

VS 150

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76876
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76876
Registered No.

1. NAME OF DECEASED (Type or Print): Frank William Herman Prillwitz
2. DATE OF DEATH: July 29, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Marine Hospital
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4811 Pennington Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	May 7, 1879	70	2 / 27	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CG Retired		Germany	USA

13. FATHER'S NAME: Frederick Prillwitz
14. MOTHER'S MAIDEN NAME: Henrietta ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
Yes		?

17. INFORMANT: Records - US Marine Hospital, Balto., Md — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary sclerosis with occlusion, and	
	DUE TO cardiac hypertrophy with failure.	unknown
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Hypertensive cardiovascular disease	unknown

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Nov 9, 1948, *to* Jul 29, 1949, *that I last saw the deceased alive on* Jul 29, 1949, *and that death occurred at* 7:05a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James M. Swanson M. D.	U. S. Marine Hospital	7/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-3-49	Balto. National	Prudent Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams, M.D.	Sadler & Dill	1501 E Fayette

VS 150

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G76877

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76877

1. NAME OF DECEASED (Type or Print): JOSEPH LEVINE

2. DATE OF DEATH: August 1, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: 36 Yrs. ~~Mos. Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3508 Reisterstown Road 15-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Married	1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Mendel
14. MOTHER'S MAIDEN NAME: Esther

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ida Levine ADDRESS: 3508 Reist Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L. Rose M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 8-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 8-2-49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): New York N.Y.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Levine
ADDRESS: 2100 Eutaw Pl

VS 151

94a

G76878

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76878

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MATTHEWS — SEAURUSAITIS

2. DATE OF DEATH: July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 416 W. Pratt Street 4-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Divorced	? 1893	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Lithuania	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		215-09-7619	Vera Phulomis Paulonis	417 W.Pratt

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I (A)	Cerebral thrombosis	
DUE TO	Diabetes mellitus	
(B)		
DUE TO		
(C)		
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Royer M.D.		8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Aug 3-49	Holy Cross Cem	Anundel County Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams, M.D.	Joseph Kasumkas Jr	607 West Pratt

VS 151

G76879 BALTIMORE CITY HEALTH DEPARTMENT 46 G76879

BIRTH NO. B.C.-49-05496 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) (emv) Mary E. Lockett

2. DATE OF DEATH July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1634 Ellsworth St. 8-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Single	Mar. 1949	XXXX	4			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME Walter Lockett

14. MOTHER'S MAIDEN NAME Rosielee Henry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Rosielee Lockett ADDRESS 1634 Ellsworth St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. . .

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* ——— Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE C. J. Pelham M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED July 30 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8-2-1949

24C. NAME OF CEMETERY OR CREMATORY Calvary

24D. LOCATION (City, town, or county) (State) A. A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 2 1949

REGISTRAR'S SIGNATURE Washington Williams, M.D.

25. FUNERAL DIRECTOR Rayner Sanders ADDRESS 1412 E. Preston St

VS 151

161a

G76880

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

Registered No. G76880

1. NAME OF DECEASED (Type or Print) CHRISTINE BARBER

2. DATE OF DEATH August 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1214 Argyle Avenue 17-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	colored	widowed	May 20, 1911	38	2 / 12	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Bedford County, Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jack Bonds

14. MOTHER'S MAIDEN NAME Willie Lee Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS
Rev. Clark 605 Hunterdon St., Newark, N.J

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular Disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE William J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED August 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) removal

24B. DATE 8-2-49

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State) Bedford County, Virginia

DATE RECEIVED BY LOCAL REGISTRAR AUG 2 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS
Robert L. Young 1532 E. Monument Street

VS 151

93d

G76881

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76881 Registered No.

1. NAME OF DECEASED (Type or Print) MRS Sylvia Praley (SYLVIA ANNA PRALEY)

2. DATE OF DEATH 7-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospt.
C. Length of stay in Baltimore Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore (6)
D. STREET ADDRESS (If rural, give location) 4210 Shamrock Ave 26-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Widowed.	6-23-83	66	1	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House-wife		Baltimore	U.S.A.

13. FATHER'S NAME John Novak

14. MOTHER'S MAIDEN NAME Barbara Dusek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Emily Wissing ADDRESS 4210 Shamrock Ave Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-26 1949 *to* 7-30 1949 *that I last saw the deceased alive on* 7-30 1949 *and that death occurred at* 12 10 *m., from the causes and on the date stated above.*

23A. SIGNATURE Richard C. Hayden M.D. | 23B. ADDRESS Bon Secours Hosp | 23C. DATE SIGNED 7-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/3/49 | 24C. NAME OF CEMETERY OR CREMATORY Oak Hill Bohemian | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 2 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Chas. J. Evans & Son | ADDRESS 118 West Mount Royal ave.

VS 150

94a

G76882

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76882
Registered No.

1. NAME OF DECEASED (Type or Print) MARY E. LORDEN

2. DATE OF DEATH 7/31/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1444 Aisquith street

c. Length of stay in Baltimore 38 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1444 Aisquith street 9-9

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	Single	1/1/1873	76	6 / 30	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10B. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Lorden

14. MOTHER'S MAIDEN NAME: Bridget Scott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Miss Susan A. Lorden ADDRESS: 1444 Aisquith stre

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO

(B) Coronary Arteriosclerosis ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1445/30 19__, *to* 7/31, 19 49, *that I last saw the deceased alive on* 7/31, 1949, *and that death occurred at* 1 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sol Smith M. D. | 23B. ADDRESS: 1223 E North Ave | 23C. DATE SIGNED: 8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/3/49	St. Mary's, Govans	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Chas J. Evans & Son, Inc. ADDRESS: 118 West Mount Royal ave.

VS 150

94a

76883

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 7.8 E 9 G76883

Registered No.

N-806-N

1. NAME OF DECEASED (Type or Print) Melvin N Pruitt

2. DATE OF DEATH 7/30/49

3. PLACE OF DEATH: A. Baltimore City, Maryland University Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore 3 days (Yrs. Mos. Days)

USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE at Baeto Co

b. COUNTY Balto

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 5600 St Marys

d. STREET ADDRESS (If rural, give location) Catonsville Md

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	married	7/28/15	34		2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales Manager	Plant	Maryland	U.S.

13. FATHER'S NAME William L Pruitt

14. MOTHER'S MAIDEN NAME Arline Chaney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		212-03-3404	Mrs Mildred Pruitt	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractures of Cervical Vertebrae

DUE TO

(B) c transection of cord.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) river

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Patapsco River off of Liberty Rd. near Balto Co Randalstown, Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 27, 1949 7 p.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21F. HOW DID INJURY OCCUR? Dived into shallow water

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L Kruger M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 31 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/3/49

24C. NAME OF CEMETERY OR CREMATORY Edwards Chapel

24D. LOCATION (City, town, or county) (State) Balto Co

DATE RECEIVED BY LOCAL REGISTRAR AUG 2 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Mac Nabb and Son

ADDRESS 186a

VS 151

G76884

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

Registered No. G76884

1. NAME OF DECEASED (Type or Print): ROSA HEBRON

2. DATE OF DEATH: 8-I-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 624 N. Bruce Street
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore I7,
D. STREET ADDRESS (If rural, give location): 624 N. Bruce Street 16-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Married	Dec. 7, 1900	48	7	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Baltimore, Md,.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Milburn
14. MOTHER'S MAIDEN NAME: Pricilla Efford
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Charlie Hebron-624 N. Bruce St, ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-Vascular Disease & Marked Decompensation
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 months

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/29 1949 *to* 8/1 1949 *that I last saw the deceased alive on* 8/1 1949 *and that death occurred at* 6.35 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE: Ralph W. Redden M.D.
23B. ADDRESS: 416 N. Gilmor St
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-3-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore 30,.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949
REGISTRAR'S SIGNATURE: Curtis Williams, M.D.
25. FUNERAL DIRECTOR: Wm. A. Jackson - 916 Penna., Ave. (I.)
ADDRESS

VS 150

93d

G76885

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

Registered No. G76885

1. NAME OF DECEASED (Type or Print) George Conrad Preller, — 2. DATE OF DEATH 8/1/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 203 N Wolfe St.
c. Length of stay in Baltimore 85 Yrs. 11 Mos. 30 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) 203 N Wolfe St. 6-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W.	Widowed	Aug 3 1863.	85	11 30	1 45

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales	—	Baltimore	USA.

13. FATHER'S NAME John Preller
14. MOTHER'S MAIDEN NAME Elizabeth. Bitner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	No	None	Anthony G. Preller	203 N Wolfe St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Heart failure	3 days
	DUE TO	Arteriosclerosis	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	Old age,	
	(C)	Old cerebrovascular accident	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11 29 1948 *to* 8/1 1949, *that I last saw the deceased alive on* 7/31 1949, *and that death occurred at* 1:45 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Maurice L. Shub M. D.	1931 N Kenwood Ave	8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	AUG 3 1949	Holy Redeemer	4430 Belair Rd Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Contingent for Williams, MD	Doppel Bro	1800 E Lombard St.

VS 150

8/3a

G76886

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76886

1. NAME OF DECEASED (Type or Print) BARBARA NAGENGAST

2. DATE OF DEATH 7/31/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3408 Mt. Pleasant Ave.
c. Length of stay in Baltimore Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 21-8
D. STREET ADDRESS (If rural, give location) 3408 Mt. Pleasant Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	9/4/1866	82	10 / 27	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Md.	U.S.A.

13. FATHER'S NAME ? Erlbacher

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	?	Mary Ipes	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral accident
DUE TO
(B) Hypertension.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. Vogel Jr M. D.	2601 E. Hamond St	8-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/3/49	Sacred Heart	Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams M.D.	Lilly & Zeiler Inc.	Balto.

VS 150

83a

~~76887~~ G76887 ✓ 60 G76887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. ~~76887~~ Registered No.

1. NAME OF DECEASED (Type or Print): ELIZABETH WAGNER
2. DATE OF DEATH: 8/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2518 FAIT AVE.
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2518 FAIT AVE. 1-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	WIDOWED	2/7/1862	87	5	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
MARTIN HAAS	CAROLINE ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No NONE	?	MARIE WAGNER	SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Gangrene of left foot — INTERVAL BETWEEN ONSET AND DEATH: 10 days
(B) DUE TO: Diabetes
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. *, 19*49*, to* Aug 1 *, 19*49*, that I last saw the deceased alive on* July 31*, 19*49*, and that death occurred at* 8 25 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph Tourbey M. D.	441 S. Linwood Ave	8/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8/5/49	SACRED HEART	BALTO. CO.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams, M.D.	WILLY & ZEILER	BALTO.

VS 150

61

Dr. Edmonds
765888
2746 Alemeda Blvd/

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76888

1. NAME OF DECEASED (Type or Print): Dorothy Urban

2. DATE OF DEATH: July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4014 Ridgecroft Road
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4014 Ridgecroft Road 27-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	married	Jan. 6, 1866	83	6	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Md.	

13. FATHER'S NAME: Peter Redef

14. MOTHER'S MAIDEN NAME: Mary *

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. Joseph Urban	4014 Ridgecroft Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Arteriosclerotic Cardio Vascular Disease & Hypertension — 1944

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 24 July, 1944 *to* 31 July, 1949 *that I last saw the deceased alive on* 30 July, 1949 *and that death occurred at* 1230 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas W. Edmonds M. D.	7746 Alameda	2-Aug-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-3-49	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949

REGISTRAR'S SIGNATURE: Huntington Nottingham, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Leonard J. Ruck, 5305 Harford Road

VS 150

93d

G76889
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76889

1. NAME OF DECEASED (Type or Print): Ella M. Hoover
2. DATE OF DEATH: July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1933 W. Baltimore St.
C. Length of stay in Baltimore: 59 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 1933 W. Baltimore St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1933 W. Baltimore St. 20-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	June 16,1862	87	1 / 14	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home Duties		Carroll County, Md.	

13. FATHER'S NAME: Eli Hiltabidle
14. MOTHER'S MAIDEN NAME: Mary Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
	None	Mrs Nathaniel K. Gardner

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lymphosarcoma — Interval between onset and death: 4 yrs.
DUE TO
(B) Myocardial Degeneration — 8 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Hypostatic Pneumonia. — 2 Days.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
a. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9/8, 1938 *to* 7/31, 1949, *that I last saw the deceased alive on* 7/31, 1949, *and that death occurred at* 5:15 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Durel E. Bogrod M. D.	1905 W. Baltimore St.	8/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 5, 1949	Greenmount	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Tuttington Williams, MD	Frederick A. Cole	1313 W. Baltimore St.

VS 150

552

676890

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 v 1 G76890 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ferdinand A. Ries

2. DATE OF DEATH 7-31-49

3. PLACE OF DEATH: Baltimore City, Maryland
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 139 E. North Ave 4/2-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Divorced	June 30, 1899	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Ries
14. MOTHER'S MAIDEN NAME Josephine Barsch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes
(If yes, give war or dates of service) War 1 & 2
16. SOCIAL SECURITY NO. none
17. INFORMANT ADDRESS 5913 Burgess Avenue Mrs. Josephine Ries

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio Sclerotic Cardio
DUE TO Vascular Disease
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Unknown

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy / Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Robert B. McAdden M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	8/3/49	Parkwood Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 2 1949
REGISTRAR'S SIGNATURE Thurlington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC BALTIMORE - 13, MARYLAND

932

G76891

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1-1 G76891

Registered No.

1. NAME OF DECEASED (Type or Print): KATHERINE EARLE FROEHLICH

2. DATE OF DEATH: July 31,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4405 Glen Arm Avenue

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4405 Glen Arm Avenue 26-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	July 16, 1870	79		15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: August F. Weis

14. MOTHER'S MAIDEN NAME: Margaretta Nitzel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: 4405 Glen Arm Avenue - 6
Mrs. Bessie T. Krause

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1949, *to* July 31, 1949, *that I last saw the deceased alive on* July 31, 1949, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis J. Kroll M. D.

23B. ADDRESS: 1801 Eutaw Pl

23C. DATE SIGNED: 8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 8/3/49

24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR (ADDRESS): HENRY SANDER & SONS, INC
BALTIMORE - 13, Maryland

VS 150

94a

G76892

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76892

Registered No.

1. NAME OF DECEASED (Type or Print): MARION SHANKLIN

2. DATE OF DEATH: Aug. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 639 S. Rappola Street
c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 639 S. Rappola Street 26-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	widower	Oct. 4, 1884	64	9	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Brass Moulder	Beth Steel Co.	Maryland	USA

13. FATHER'S NAME: Marion Shanklin, Sr.

14. MOTHER'S MAIDEN NAME: Annie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: 639 S. Rapolla St. Mrs. Marie Dowling

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-23-48, 19__, *to* 8-2-49, 19__, *that I last saw the deceased alive on* 8-1-49, 19__, *and that death occurred at* 8 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John Constantine, M. D.	234 S. Conkling Street	8-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	8/5/49	Parkwood Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 2 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND

93d

G76893

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 20 1

G76893

Registered No.

1. NAME OF DECEASED (Type or Print): James F. Hayden

2. DATE OF DEATH: 7-31-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2827 Pelham Ave.
c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. City
D. STREET ADDRESS (If rural, give location): 2827 Pelham Ave. 27-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	7-1-1889	60		30		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Police Officer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Francis J. Hayden
14. MOTHER'S MAIDEN NAME: Ella Cadden
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Marie E. Brewster ADDRESS: 2827 Pelham Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Embolism	1 hr
DUE TO	arterio Sclerosis	3 mo
	Hypertension	3 mo
(B)	Mitral Regurgitation (Decomp)	3 mo
DUE TO		
(C)	Chronic Interstitial Nephritis	3 mo

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 30, 1949 *to* July 31, 1949, *that I last saw the deceased alive on* July 30, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: F. F. A. Stevens M. D.
23B. ADDRESS: 2878 Harford Rd
23C. DATE SIGNED: 8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-4-1949
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 2 1949
REGISTRAR'S SIGNATURE: Huntington for Williams, M.D.
25. FUNERAL DIRECTOR: Flynn & Fleming ADDRESS: 1426 Light St.

VS 150

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G76894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

69-5

G76894 Registered No.

BIRTH NO. B.C.49-15973

1. NAME OF DECEASED (Type or Print): MALE INFANT BENNER

2. DATE OF DEATH: 8-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 16-8
D. STREET ADDRESS (If rural, give location): 907 Wildwood Parkway

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	S	8-1-49			15 / 9

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	MARYLAND	U.S.

13. FATHER'S NAME: GEORGE CONRAD BENNER

14. MOTHER'S MAIDEN NAME: RUTH AMELIA HOLLINGSWORTH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		MR BENNER	907 Wildwood Pkway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ATELECTASIS
DUE TO
(B) PREMATURITY
DUE TO
(C) Maternal Toxemia of Pregnancy

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-1, 1949 *to* 8-2, 1949 *that I last saw the deceased alive on* 8-2, 1949, *and that death occurred at* 2:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George Bronos M. D.	Maryland General Hosp	8-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	8/3/49	Loudon Park	Lot 12 - Sec X

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 2 1949	Huntington Williams, M.D.	Chas P. Towell	4427 Edmondson Ave

VS 150

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G76895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53.3 G76895

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Louis Doebereiner

2. DATE OF DEATH 8/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 29 E. North Avenue

c. Length of stay in Baltimore About 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 29 E. North Avenue 12-5

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH ------1879
9. AGE (In years last birthday) About 70
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY Confectioner
11. BIRTHPLACE (State or foreign country) Baltimbre, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Christian Doebereiner
14. MOTHER'S MAIDEN NAME Johanna Pettroff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS Mrs. Emma D. Hughes 29 E. North Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH 1 day

DUE TO

(B) Epilepsy - Recurrent Attacks — Several Years

DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. —, 1949 *to* Aug 1, 1949 *that I last saw the deceased alive on* July, 19—, *and that death occurred at* 12 10 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE W. B. McSherry M. D.
23B. ADDRESS 31 E. North Ave
23C. DATE SIGNED Aug. 2. 1949

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify) Burial
24B. DATE 8/3/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 2 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR AND ADDRESS H. W. Meeks and Son 805 N. Calvert St.

VS 150

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G76896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4300 Registered No. G76896

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE CAMPBELL

2. DATE OF DEATH August 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balto.

D. STREET ADDRESS (If rural, give location)
2026 Eutah Place 14-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	March 12 1900	48 49	4	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Factory Worker		West Va.	

13. FATHER'S NAME
Luther Campbell

14. MOTHER'S MAIDEN NAME
Mertie Wentz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS
Mrs. LeClyde Hedrick Elkin

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subacute bacterial endocarditis

DUE TO

(B) with occlusion of left coronary vessel

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Earl L. Rose M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED August 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burned

24B. DATE Aug 5th 1949

24C. NAME OF CEMETERY OR CREMATORY Kavanaugh

24D. LOCATION (City, town, or county) (State) Upshur Co. West Virginia

DATE RECEIVED BY LOCAL REGISTRAR AUG 3 - 1949

REGISTRAR'S SIGNATURE Thurlington Williams, M.D.

25. FUNERAL DIRECTOR Charles P. Towell ADDRESS 2427 Edmondson Ave

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VS 151

76897 CERTIFICATE CORRECTED 8-9-49 ✓ X

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

CERTIFICATE OF DEATH

193 Registered No. G76897

1. NAME OF DECEASED (Type or Print) STEWARD-JACOBS

2. DATE OF DEATH aug-9-1899 2-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore Yrs. 20 Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Penna B. COUNTY adams
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Littlestown
D. STREET ADDRESS (If rural, give location) Lombard Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	aug. 9-1899	49	11	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foundry Employee
10B. KIND OF BUSINESS OR INDUSTRY Foundry
11. BIRTHPLACE (State or foreign country) York Co. Penna.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Emanuel Jacobs
14. MOTHER'S MAIDEN NAME Mary Catherine Ruby
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 185-05-8855
17. INFORMANT Mrs Steward Jacobs ADDRESS Littlestown PA Lombard St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hydrocephalus — INTERVAL BETWEEN ONSET AND DEATH ? 3 mos

DUE TO

(B) Extension of brain tumor — 3 mos

DUE TO

(C) Oligodendroglioma, left frontal — 6 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION Oct. 1948
19B. MAJOR FINDINGS OF OPERATION Oligodendroglioma, left frontal lobe
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 27 1949 to Aug 2, 1949, that I last saw the deceased alive on Aug 2 1949, and that death occurred at 10 PM m., from the causes and on the date stated above.

23A. SIGNATURE R. M. N. Crosby M. D.
23B. ADDRESS University Hospital
23C. DATE SIGNED Aug 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal for Burial
24B. DATE 8/5/49
24C. NAME OF CEMETERY OR CREMATORY Mt Carmel Cem.
24D. LOCATION (City, town, or county) (State) Littlestown, Adams Co. PA

DATE RECEIVED BY LOCAL REGISTRAR AUG 3 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR J. W. Little & Son
ADDRESS Littlestown PA

VS 150

54a Rep R. H. Little

6898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 902.0

G76898 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jessie Murvin Gaskill N 805.0

2. DATE OF DEATH July 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Marine Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New Jersey
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Newark
D. STREET ADDRESS (If rural, give location) 87 New St.

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 3/27/18
9. AGE (In years last birthday) 31 If Under 1 Year: Months 3- Days 25 If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) NC
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Gaskill
14. MOTHER'S MAIDEN NAME Sabro Tolson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 083-18-5667
17. INFORMANT Records-US Marine Hospital, ADDRESS Balto. Md.

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Fracture of thoracic vertebrae

DUE TO

(B) fracture of pelvis.

DUE TO

(C) fatty Degeneration of liver

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home(Sleeping there)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 702 S. Broadway (3rd floor) 2-3
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 18, 1949 2 A m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fall from roof to ground (3rd floor)

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X] suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Carl L. Engel M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED July 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal
24B. DATE August 3, 1949
24C. NAME OF CEMETERY OR CREMATORY OCRACOKE CEMETERY
24D. LOCATION (City, town, or county) (State) OCRACOKE, N. CAR.

DATE RECEIVED BY LOCAL REGISTRAR AUG 3 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR William Cook, Inc. ADDRESS 1217 St. Paul Street

VS 151

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76899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 91.6 G76899

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) C. CONRAD FRIEDAL (FRIEDEL) N-803-4

2. DATE OF DEATH August 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN Timonium (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 27 Oakley Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white		Dec. 3, 1874	74	7	30		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Night Watchman	Davis Const. Co.	Baltimore, Maryland	

13. FATHER'S NAME
Joseph Friedel

14. MOTHER'S MAIDEN NAME
Margaret Dorn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
Unknown		218-07-8971

17. INFORMANT — ADDRESS
Louis Friedel — 5 York Road Timonium Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

DUE TO

(B) Intracranial Hemorrhage

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

VOID

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (In or about home, farm, factory, street, office bldg., etc.): school

WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): new school at Sandy Bottom, York Road

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 30, 49 6 p. m.

21E. INJURY OCCURRED: WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR? Struck on head by falling wood during storm

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Emil L Beyer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: August 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 5, 1949	Sacred Heart Cem	Baltimore Co. Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	Huntington Williams, M.D.	William Cook, Inc.	1217 St. Paul Street

VS 151

1952

Gordon

527

G76900

304

G76900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) White William W

2. DATE OF DEATH 7-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Pine Crest Sanitorium

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address or location) Pine Crest Sanitorium

c. Length of stay in Baltimore 40 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
114 S. Curley St. Baltimore Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) 1-2
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
M	White		2-10-1867	82	5 / 20	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter

10B. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? Baltimore

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT ADDRESS Pine Crest Sanitorium

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility with Senile psychoses — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) B Bronchopneumonia

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerosis — 0 days

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 5, 1949 *to* July 29, 1949, *that I last saw the deceased alive on* July 29, 1949, *and that death occurred at* 3.27 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Melvin N. Borden M. D.

23B. ADDRESS 2030 W Fayette St

23C. DATE SIGNED 8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8-3-49

24C. NAME OF CEMETERY OR CREMATORY Meadow Ridge Cem.

24D. LOCATION (City, town or county) (State) Washington Blvd Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 3 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR David R. Martin

ADDRESS

VS 150

107

G76901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 1 7 0

G76901 Registered No.

BIRTH NO. BC. 49-07755

1. NAME OF DECEASED (Type or Print) JERRY STAVIS (TERRY SAVAGE) (BN 6994)

2. DATE OF DEATH July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 723 Hanover Street 22-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
male	colored	Child

8. DATE OF BIRTH 4/14/49

9. AGE (In years last birthday) — If Under 1 Year: Months 3, Days 17; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Garnett Savage (Isaac Burley)

14. MOTHER'S MAIDEN NAME Annie Smoot

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Annie Savage ADDRESS 723 S. Hanover St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mechanical Suffocation — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 723 Hanover Street 22/1

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY July 31, 1949 ? m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Accidentally suffocated by bedclothes

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Earl L Royer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED August 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/3/49	Mount Calvary Cemetery	A, A. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 3 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS J. L. Brown & Son - 1020 Montgomery St

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6902 BALTIMORE CITY HEALTH DEPARTMENT 71-5 G76902

BIRTH NO. B.C. 49-5737 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Petcholon Baby Girl

2. DATE OF DEATH: Aug 2 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-5
D. STREET ADDRESS (If rural, give location): 4400 Fairhaven Ave

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 7-31-49
9. AGE (In years last birthday) | If Under 1 Year: Months | Days: 3 | If Under 24 Hours: Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Petcholon
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PREMATURITY - 1500 gms
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Petechial hemorrhages in lung & heart

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-31 1949 *to* 8-2 1949, *that I last saw the deceased alive on* 8-2 1949, *and that death occurred at* 8:10 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Harrison C. Spencer, M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 8/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. 5/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross agco
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: AUG 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR ADDRESS: Fred W Ozazewski 159 1930 Eastern Ave

VS 150

76903

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76903

Registered No.

1. NAME OF DECEASED (Type or Print): MARGARET ELLEN TILGHMAN

2. DATE OF DEATH: Aug. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2510 Guilford Ave.
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2510 Guilford Ave. 12-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Widowed	Nov. 7, 1878 about	about 70	8	25

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Md.	

13. FATHER'S NAME: Alfred Stinchcomb

14. MOTHER'S MAIDEN NAME: - Pumphrey Hester Ann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-no		Mr. Richard Tilghman	2510 Guilford Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
DUE TO
(B) Myocarditis & arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 15, 1949 *to* Aug 1, 1949 *that I last saw the deceased alive on* Aug 1, 1949, *and that death occurred at* 1145 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Kadrl M. D.	2306 Eutaw Pl.	8-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/4/49	Woodlawn Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

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G76904

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43

G76904

Registered No.

1. NAME OF DECEASED (Type or Print): MARY E. BAKER

2. DATE OF DEATH: July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wheeler Nursing Home 1700 Park Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5001 Herring Run Drive 27-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Widowed	Dec. 14, 1868	80 yrs.	7	17

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	A. A. Co., Md.	

13. FATHER'S NAME: John Davies

14. MOTHER'S MAIDEN NAME: - Hancock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Albert Baker ADDRESS: 5001 Herring Run Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs
DUE TO Cardiac Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Heart Disease, Hypertensive — 5 yrs
DUE TO Arteriosclerosis, General — 15 yrs

(C) Cerebral Thrombosis, onset — 5/9/49

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9 May, 1949, *to* 31 July, 1949, *that I last saw the deceased alive on* 31 July, 1949, *and that death occurred* 11 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Bruns M. D.	20 W E Baltimore Apt	2 Aug 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/3/49	Western Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

93d

BIRTH NO. 76905

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

53 Registered No. 076905

1. NAME OF DECEASED (Type or Print): ANNIE S. ENGEL

2. DATE OF DEATH: Aug. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2756 Winchester St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2756 Winchester St. 16-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Sept. 19, 1861	87 yrs.	10 / 13	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Manchester, Md.	

13. FATHER'S NAME: David T. Shaffer

14. MOTHER'S MAIDEN NAME: Mary Burns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		no

17. INFORMANT: Mrs. Charles G. Starner ADDRESS: 2756 Winchester St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriosclerosis, cerebral

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from July 15, 1949, to August 1, 1949, that I last saw the deceased alive on August 1, 1949, and that death occurred at 10:00 P. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Abraham B. Hurwitz M. D.	3048 W. North Ave.	August 3 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/5/49	Woodlawn Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

462

BIRTH NO. 76906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

433.1

Registered No. 76906

1. NAME OF DECEASED (Type or Print): Mrs. Ethel H. (Clarence) Schaumon

2. DATE OF DEATH: 8/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 106 Bellemore Rd. 27-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	Jan 1, 1887	62	7 / 1	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Franklin Armacost

14. MOTHER'S MAIDEN NAME: S. Lillian Campbell.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Clarence Schaumon ADDRESS 3 same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: almost instantaneous

DUE TO

(B) fever of unknown etiology — 2/12/49 - 8/2/49.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2-12-49, 19__, *to* August 2, 1949, *that I last saw the deceased alive on* August 2, 1949, *and that death occurred at* 3 35 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Charles Gramlich M. D.	Union Memorial Hospital	August 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/5/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	Curtis Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

95a

G76907

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 49-1485-4 **CERTIFICATE OF DEATH** 761.5 Registered No. G76907

1. NAME OF DECEASED (Type or Print): ARMSTRONG BABY GIRL

2. DATE OF DEATH: July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days: 10½ hours

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1222 Pennsylvania 17-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Single	July 21, 1949			10 20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant	none	Maryland	U.S.A.

13. FATHER'S NAME: James Brown

14. MOTHER'S MAIDEN NAME: Mazzie Briscoe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	none	Mother	1222 Pennsylvania

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 10 Hrs.
DUE TO
(B) Extrauterine Intestation — 10½ hrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Prematurity

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	none	none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	none

22. *I hereby certify that I attended the deceased from* July 21, 1949 *to* July 21, 1949 *that I last saw the deceased alive on* July 21, 1949, *and that death occurred at* 2:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles I. Henderson M. D.	University Hospital	July 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	JUL 2 8 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	Thurlington Williams, M.D.	Commissioner of Health	

VS 150

160C

76908

BIRTH NO. 49-15034

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76908 Registered No.

1. NAME OF DECEASED (Type or Print): Clara Mae Wideman

2. DATE OF DEATH: 7-23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland ✓

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days: 9 hours 50 min.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 821 Parrish Street 16-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	NEGRO	SINGLE	July 22, 1949	9 hours	50 MINUTES	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INFANT	none	MARYLAND	U.S.A.

13. FATHER'S NAME: Robert E. WIDEMAN

14. MOTHER'S MAIDEN NAME: MATTIE HOUSTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		none	MOTHER	821 North Parrish St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 9 hours
DUE TO
ANTECEDENT CAUSES
(B) atelectasis, pulmonary — 9 hours
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prematurity - 2lbs 11 ounces

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	none	none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	none

22. *I hereby certify that I attended the deceased from* July 22, 1949, *to* July 23, 1949, *that I last saw the deceased alive on* July 23, 1949, *and that death occurred at* 5:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
E. B. Middleton M.D.	U. Hospital	July 23 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	JUL 28 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

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76909

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 49-15029

CERTIFICATE OF DEATH

Registered No. G76909

1. NAME OF DECEASED (Type or Print): RALEIGH, GERALD

2. DATE OF DEATH: JULY 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
c. Length of stay in Baltimore: 1 ~~Year~~ ~~Month~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1060 W. VINE ST. 18-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	COLORED	SINGLE	JULY 24, 1949			1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	INFANT	MARYLAND.	U.S.A.

13. FATHER'S NAME: JAMES LAWRENCE RALEIGH

14. MOTHER'S MAIDEN NAME: MARIE SCIPIO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		MARIE RALEIGH	1060 W VINE ST Baltimore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) SEPTICEMIA OF NEWBORN — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY
DUE TO
(B) PNEUMONIA
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JULY 25, 1949 *to* JULY 25, 1949 *that I last saw the deceased alive on* JULY 25, 1949 *and that death occurred at* 10:45 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edmund B. Middleton M.D.	UNIVERSITY HOSPITAL	JULY 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	JUL 28 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	Huntington Williams, M.D.	Commissioner of Health	

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76910 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76910

1. NAME OF DECEASED (Type or Print): Harry A. Montgomery

2. DATE OF DEATH: Aug 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION — (If not in hospital or institution, give street address or location): 112 E. Gittings St.
C. Length of stay in Baltimore: 45 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 30 Md.
D. STREET ADDRESS (If rural, give location): 112 E. Gittings St. 24-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	widowed	Dec. 23, 1869	79	7	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
pipe-fitter	B.&O. Railroad	Chambersburg Penn.	

13. FATHER'S NAME: Augustus Montgomery

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	no	none	James V. Montgomery	500 Normandy Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gastric Hemorrhage — DUE TO

ANTECEDENT CAUSES
(B) Cirrhosis of Liver (Alcoholic) — DUE TO
(C) — DUE TO

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Arteriosclerotic Heart Disease.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 10, 1949 *to* Aug. 1, 1949 *that I last saw the deceased alive on* July 30, 1949, *and that death occurred at* 8 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. P. Friedman, M. D. M. O.	1319 Light St. - Balto. 30	8/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	Aug. 3 1949	Glen Haven Cemetery	Ritchie Highway Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 3 1949	Huntington Williams, M.D.	Krause Funeral Home 1216 S. Charles St

VS 150

124a

G76911

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76911

1. NAME OF DECEASED (Type or Print): Emma M. Heim

2. DATE OF DEATH: August 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2712 Ashland Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2712 Ashland Ave.,

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	April 25, 1875	74	3	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home		Balto	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ludk Dsmleng	Emma Mosa

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Victor Heim	2712 Ashland Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO

(B) Chr. Myocardial Degeneration

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 3, 1949, *to* Aug 2, 1949, *that I last saw the deceased alive on* June 3, 1949, *and that death occurred at* 10:20 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Vincent H. Doolan M. D.	2623 E. Monument St	8/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 5/49	Balto Cem	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	Huntington Williams, M.D.	Uhl Funeral Home	2008 Adams

VS 150

93d

G76912

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76912

1. NAME OF DECEASED (Type or Print): George L Eckstein

2. DATE OF DEATH: July 31/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2016 Hoffman St.
C. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 2016 Hoffman 8-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	married	April 7, 1894	55	3	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Barber	Balto	

13. FATHER'S NAME: Charles Eckstein

14. MOTHER'S MAIDEN NAME: Catherine Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Catherine Eckstein	2016 Hoffman

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coma & Convulsions — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO
(B) Pulmonary Edema
DUE TO
(C) Coronary Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 7/1, 1949, to 7/31, 1949 that I last saw the deceased alive on 7/30, 1949, and that death occurred at 8:4 m. from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank L. Hurley M.D. M. D.	3323 E Balto St	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 3/49	Oak Lawn Cem	Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	Huntington Williams, M.D.	Uhl & Funeral Home	2008 Aliceanna

VS 150

94a

G76913 | BALTIMORE CITY HEALTH DEPARTMENT | 54 | G76913

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): William Booker

2. DATE OF DEATH: July 23 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): So. Balto. General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 107 Welcome Alley 22-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	S	March 29 1892	57	3 / 24	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARCINOMA OF THE RECTOSIGMOID
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: CHRONIC NEPHRITIS

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* 5/21, 1949 *to* 7/23, 1949, *that I last saw the deceased alive on* 7/23, 1949, *and that death occurred at* 3:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Samuel P. Scalia M. D.
23B. ADDRESS: 1213 E. Eight Street
23C. DATE SIGNED: 7/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): JUL 28 1949

DATE RECEIVED BY LOCAL REGISTRAR: AUG 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

46d

G76914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76914

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEO FISCHER

2. DATE OF DEATH 7-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore Unknown Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md.
D. STREET ADDRESS (If rural, give location) 2701 Westwood Ave 15-6

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Unknown

8. DATE OF BIRTH 1889.

9. AGE (In years last birthday) 60 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Unknown

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown.

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 7 Hrs

DUE TO (B) Arteriosclerotic + Hypertensive Cardio-Vasc. Disease — ?

DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-23 1949 *to* 7-23, 1949, *that I last saw the deceased alive on* 7-23, 1949, *and that death occurred at* 8-30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE David Auld M. D.

23B. ADDRESS University Hosp.

23C. DATE SIGNED 7-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL JUL 28 1949

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR AUG 3 1949

REGISTRAR'S SIGNATURE Tuntington Williams, M.D.

25. FUNERAL DIRECTOR Commissioner of Health

ADDRESS

VS 150

93d.

76915 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76915 Registered No.

1. NAME OF DECEASED (Type or Print) DuVAL GABRIEL SILL

2. DATE OF DEATH August 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland St. James Hotel

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
530 N. Charles St., St. James Hotel

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 530 N. Charles St., St. James St. 11-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	single	Aug 1904	44				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
architect		Maryland.	U.S.

13. FATHER'S NAME Howard Sill

14. MOTHER'S MAIDEN NAME Mary Francis DuVal

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Van Rensselaer Sill ADDRESS 219 N Piedmont St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty degeneration of liver.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED 8/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 4 49	Holy Trinity Church	Mitchellville P.G. Co

DATE RECEIVED BY LOCAL REGISTRAR AUG 3 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John O. Mitchell & Sons ADDRESS 1900 Eutaw Place

VS 151

124

76916

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

156.1 G76916 Registered No.

1. NAME OF DECEASED (Type or Print) JAMES FREDERICK MILTON

2. DATE OF DEATH 8-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours

C. Length of stay in Baltimore 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 108 W University Pkwy, 12-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	married	6-4-76	73	1	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Horse Race Starter		Texas	U.S.A.

13. FATHER'S NAME Charles A. Milton

14. MOTHER'S MAIDEN NAME Miranda Lillard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mrs Antoinette Z. Milton - Carolina Apts.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adeno-carcinoma of brain - mucin — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic hypertensive disease 15 yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 11, 19 9, *to* Aug 2, 19 9, *that I last saw the deceased alive on* Aug 2, 1949, *and that death occurred at* 9:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard C. Haydu M. D.	Bon Secours Hosp	8-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
Burial	8/5/49	New Cathedral	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 3 1949	Huntington Williams, M.D.	John O. Mitchell & Sons, Inc. - 1900 Eutaw Place

VS 150

46 f

M B Mitchell

76917

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76917 Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE KRAUSS

2. DATE OF DEATH: Aug. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 628 N. Kenwood Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 628 N. Kenwood Ave. 7-2

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 4/6/1880
9. AGE (In years last birthday): 69 (If Under 1 Year: Months 3, Days 26; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY: The Hub

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Rita Cleary-dght. ADDRESS: 632 N. Kenwood Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery insufficiency — 4½ mos.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* March 16, 1949 *to* Aug 1, 1949 *that I last saw the deceased alive on* July 30, 1949, *and that death occurred at* 4:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm D Schimunek M. D.
23B. ADDRESS: 701 N. Kenwood Ave.
23C. DATE SIGNED: Aug 1-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/4/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State): 4430 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

94a

G76918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76918

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sadie Scott Bonner

2. DATE OF DEATH: JUL 30 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 411 Dusham St 6-4

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 6-22-16
9. AGE (In years last birthday): 33
If Under 1 Year: Months / Days 8
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): No. Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Chester Bonner
14. MOTHER'S MAIDEN NAME: Mamie Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia + Septicemia
DUE TO
(B) Agranulocytosis
DUE TO
(C) ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7.30 1949 *to* 7.30 1949, *that I last saw the deceased alive on* 7.30 1949, *and that death occurred at* 11 05 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm. Wm W. Winternitz M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 7-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: aug 3-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn Md
25. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: Brantley Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

VS 150

108

BIRTH NO. G76919

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 43 G76919

1. NAME OF DECEASED (Type or Print): WILLIE BEATRICE PARKER

2. DATE OF DEATH: August 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp. (d.o.a.)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1129 Woodyear Street 16-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored		Nov. 1, 1901	47	9			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Salisbury, N.C.	U.S.A.

13. FATHER'S NAME: Unknown ?

14. MOTHER'S MAIDEN NAME: ? Mckee, Salisbury, N. C.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Dennis Parker, 1129 Woodyear St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? N

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl L Kruger M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: August 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-5-49	Arbutus Memorial Pk	Arbutus Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R Williams ADDRESS: Johnson St

VS 1ST

93d

BIRTH NO. G76920

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76920

1. NAME OF DECEASED (Type or Print): AGNES RICE (WRIGHT)

2. DATE OF DEATH: August 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 509 Wilson Street 14-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	colored	married	March 4, 1900	49	4	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: GeorgeW. Scott
14. MOTHER'S MAIDEN NAME: Martha Washington
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Daisy Miller ADDRESS: 2112 Druid HillAve.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic congestive heart failure
DUE TO
(B) Advanced pulmonary tuberculosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Hayes M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: August 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 5, 1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial
24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Pete R Williams ADDRESS: 3211 Schroeder St

VS 151

13B

G76921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76921 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret Johnson

2. DATE OF DEATH July 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 2709 Booker Drive, Cherry Hill
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cherry Hill,
D. STREET ADDRESS (If rural, give location) 2709 Booker Drive 25-32

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	widowed	May 6, 1900	49	7	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? Jones	Almetta Burch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Rosenda Parker	2709 Booker Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolization, acute — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Pelvic Thromboses

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/20/49	Fibromyomata (uterine); urethrocele	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/16, 1949 *to* 7/30, 1949, *that I last saw the deceased alive on* 7/30, 1949, *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Fred R. McClure M. D.	University Hosp.	7/30

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-3-49	Mt. Auburn Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
G3 1949	Estelle Williams, M.D.	Mrs Katie R. Williams	3224 Edmondson

FREDK. R. McClure

564

ES-119291 G76922 BALTIMORE CITY HEALTH DEPARTMENT G76922

CERTIFICATE OF DEATH

Registered No. 3 3

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Green

2. DATE OF DEATH 7-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto, City Hospitals
c. Length of stay in Baltimore 31 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN Balto. (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1536 Shields Place 14-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Negro	Single	Aug. 2, 1878	70	11	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Green
14. MOTHER'S MAIDEN NAME Mary Williams
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT RECORDS*BALTO CITY HOSPITALS ADDRESS 4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 12 Hrs.
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 7-26-49
19B. MAJOR FINDINGS OF OPERATION Diabetic Gangrene of Right Foot with suprecandylar amputation
20. AUTOPSY? YES [X] NO [ ]
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-29 , 19 49 , *to* 7-30 , 19 49 , *that I last saw the deceased alive on* 7-30 , 19 49 *and that death occurred at* 5:25 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE R. S. Rosen M. D.
23B. ADDRESS 4940 Eastern Avenue
23C. DATE SIGNED 8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8-3-49
24C. NAME OF CEMETERY OR CREMATORY W. F. Auburn Am.
24D. LOCATION (City, town, or county) Balto. (State) Md.
25. FUNERAL DIRECTOR Mrs Katie R Williams
ADDRESS 321 N Schroeder St

DATE RECEIVED BY LOCAL REGISTRAR AUG 3 1949
REGISTRAR'S SIGNATURE

VS 150

061

G76923 G76923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Drucilla Price

2. DATE OF DEATH 7-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hosp

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY ~~OR TOWN~~ Baltimore 16-4
D. STREET ADDRESS (If rural, give location) 1830 W. Lanvale St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	Colored	Married	[illegible]1898	51	50	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Calvert Co., Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown (Mr. Gray)	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mrs. Wm. Price	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B) Hypertension

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
None		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 7-30, 1949, to 7-31, 1949, that I last saw the deceased alive on 7-31, 1949, and that death occurred at 1:25 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lucius W. Lacper M. D.	Provident Hosp.	Aug. 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 4, 1949	Arbutus Memorial	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	[illegible] Williams, M.D.	Mrs Katie R Williams	Schroeder

VS 150

83a

BIRTH NO. G76924

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

051 G76924 Registered No.

1. NAME OF DECEASED (Type or Print): Anna Kate Grayson

2. DATE OF DEATH: 7-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1928 Laurette Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1928 Laurette Ave. Baltimore Md.
D. STREET ADDRESS (If rural, give location): 1928 Laurette Ave. 20-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	C	Married	6-16-1895	54 53	1	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Valdosta Ga.	U.S

13. FATHER'S NAME: John Rutledge
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		husband Clifford Grayson	1928 Laurette Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Streptoccus throat — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
(B) Low Blood
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cardio-Vascular-Renal disease years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 24, 1949, to July 31-49, *that I last saw the deceased alive on* 7-30-49, *and that death occurred at* 1:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
I N Cardozo M. D.	1524 Druid Hill Ave	8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-4-49	Arbutus Memorial	Arbutus Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	Hunter Jon Williams M.D.	Wm. Katie R. William	922 N. Johnson St.

VS 150

1312

G76925

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

181 G76925
BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John Chester King

2. DATE OF DEATH 8-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland The Union Memorial Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union memorial Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Allegany
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ft Cumberland
D. STREET ADDRESS (If rural, give location) 429 Cumberland St. Cumberland Md

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	4-18-1885	64	3	16		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Carpenter	West Virginia	U.S.A.

13. FATHER'S NAME James King

14. MOTHER'S MAIDEN NAME Sofie Race King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT wife ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of urinary bladder — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Ext. peritoneal abscess, left due to ruptured bladder

DUE TO

(C) Hydronephrosis, bilateral.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 24, 1949, to 8/2, 1949, *that I last saw the deceased alive on* 8/2, 1949, *and that death occurred at* 5:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles H. Watt Jr., M.D.	Union Memorial Hospital	8-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-6-49	St. Peter & Paul	Cumberland, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	Curtis Williams, M.D.	John A. Moran	3000 E Balto. St.

VS 150

G76926

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76926

1. NAME OF DECEASED (Type or Print): LESTER KATHAN HODGES

2. DATE OF DEATH: Aug. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: NY
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lake Luzerne
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Single	7/19/93	56		14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
oiler	Seafarer	?	USA

13. FATHER'S NAME: Edward A. Hodges

14. MOTHER'S MAIDEN NAME: Josephine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
?		547-05-6272

17. INFORMANT: Records-US Marine Hospital, Balto, Md. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CORONARY SCLEROSIS WITH OCCLUSION
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Aug. 2, 1949, *to* Aug. 2, 1949, *that I last saw the deceased alive on* Aug. 2, 1949, *and that death occurred at* 4:22 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Medical Director M. D.	US Marine Hospital, Balto, Md.	8/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 6	Lake Luzerne N.Y.	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	[illegible]	Ellsworth Bancroft	518 Gunpowder Ave

VS 150

94a

G76927 BALTIMORE CITY HEALTH DEPARTMENT G76927

CERTIFICATE OF DEATH

43 V 1 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Amelia West

2. DATE OF DEATH July 30 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 314 Greene St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 314 S Greene St 2272

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Col		Oct 24 1897	51	9	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	Ø	Balto Md 62	

13. FATHER'S NAME John Miller

14. MOTHER'S MAIDEN NAME Emma Hunter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Hattie Jackson	628 Hope St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH 2 Hr

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Royer M.D.		31 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 4 49	Mt Olivet Cemetery	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 3 1949	Huntington Williams, M.D.	Isaiah L Brown	1105 N Montgomery

932

G76928 CERTIFICATE CORRECTED 8-15-49 G76928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH COSSENTINO

2. DATE OF DEATH 8-1-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 137 S. CENTRAL AVE

c. Length of stay in Baltimore 47 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. City.

D. STREET ADDRESS (If rural, give location) 137 S. Central ave 3-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	WHITE	WIDOWED	3/29 (1876)	73 (74)	4	13		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER		NAPLES ITALY	AMERICA

13. FATHER'S NAME ANTHONY COSSENTINO

14. MOTHER'S MAIDEN NAME TOMMASINA MIELE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO		

17. INFORMANT Tommasina Barozzo ADDRESS 135 S Central Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocardial dis: DUE TO Hypertrophy & dilatation.

(B) Auricular Fibrillation DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 YRS -

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 3 45 *to* Aug 1 49, *that I last saw the deceased alive on* 8-1 49 *and that death occurred at* 4 20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Anthony F Carozza M.D. 23B. ADDRESS 5217 York Rd 23C. DATE SIGNED 8/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 4. 49	Holy Redeemer	Belair Road

DATE RECEIVED BY LOCAL REGISTRAR: AUG 3 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wendell J Keppel ADDRESS 812. S Highland ave

93d

Hospital Disposal

G76929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76929 Registered No.

BIRTH NO. B.C. 49-15045

1. NAME OF DECEASED (Type or Print): Baby Boy McCint

2. DATE OF DEATH: July 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1922 E. Jefferson St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Child	7-23-49				7	5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: Joseph McCint

14. MOTHER'S MAIDEN NAME: Marie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Immaturity
DUE TO
(B) Anoxia
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-23, 1949 *to* 7-23, 1949, *that I last saw the deceased alive on* 7-23, 1949, *and that death occurred at* 8 20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D. | 23B. ADDRESS: JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED: July 24 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY: Hosp Disposal | 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS

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G76930 — 130514 — BALTIMORE CITY HEALTH DEPARTMENT — G76930

BIRTH NO. B.C. 49-15464 — CERTIFICATE OF DEATH — Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Cheeks- Mary

2. DATE OF DEATH: July 24, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 1 day (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 573 Moore St. 17-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
F	Negro	Single	July 23, 1949			1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Melvin Cheeks

14. MOTHER'S MAIDEN NAME: Mary Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: B. C. H. Records, ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid Hemorrhage
DUE TO Atresia of the parietal bones.
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES Yes NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 23, 1949, *to* July 24, 1949, *that I last saw the deceased alive on* July 24, 1949, *and that death occurred at* 3.30PM., *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 7-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated
24B. DATE: 7-26-49
24C. NAME OF CEMETERY OR CREMATORY: B. C. H. Crematory
24D. LOCATION (City, town, or county) (State): 4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: ADDRESS:

VS 150

160a

Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76931

BIRTH NO. G79933 B.C. 49-14599

1. NAME OF DECEASED (Type or Print): Baby "Girl" Heard (Ruradell)

2. DATE OF DEATH: JUL 15 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-01
D. STREET ADDRESS (If rural, give location): 1301 Jefferson St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored		7-15-49			6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Howard Heard	Ruradell ? Lail

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO Anoxia.

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-15, 1949, *to* 7-15, 1949, *that I last saw the deceased alive on* 7-15, 1949, *and that death occurred at* 7 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Bostowick M. D.	JOHNS HOPKINS HOSPITAL	July 16, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Hosp Disposal	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 4 1949	Huntington Williams, M.D.		

VS 150

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G76932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-14546

Registered No. G76932

1. NAME OF DECEASED (Type or Print): Baby Davis

2. DATE OF DEATH: July 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. [illegible] Mos. 14 3/60 hrs Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1221 East Monument Street 5-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C		July 16, 1949				1	43

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Sam Davis

14. MOTHER'S MAIDEN NAME: Lulu Belle Richardson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: The Johns Hopkins Hospital ADDRESS: 601 N. Broadway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Immaturity

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 16, 1949 *to* July 16, 1949 *that I last saw the deceased alive on* July 16, 1949 *and that death occurred at* 6:50 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Mason C. Andrews M. D.
23B. ADDRESS: 601 North Broadway
23C. DATE SIGNED: 7-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Hoff Defense
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR:
ADDRESS:

VS 150

1-9

Hospital Disposal ✓ x 160.5

G76933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76933 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby Boy Elste

2. DATE OF DEATH: July 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Bal. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): White Marsh, Md.
D. STREET ADDRESS (If rural, give location): Ebenezer Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Child	7-21-49			1 / 45

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: James Vacek

14. MOTHER'S MAIDEN NAME: Anna Elste

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prematurity — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-21, 1949 *to* 7-21, 1949 *that I last saw the deceased alive on* 7-21, 1949, *and that death occurred at* 4:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William W. Mavin M. D.	JOHNS HOPKINS HOSPITAL	7-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Holy Redeemer	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 4 1949	Huntington Williams, M.D.		

VS 150

160a

G76934

124133

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4x0.0

G76934

Registered No.

1. NAME OF DECEASED (Type or Print) **Nicholas Stanilla**

2. DATE OF DEATH **7-27-49**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Baltimore City Hospitals 4940 Eastern Ave.**

C. Length of stay in Baltimore **?** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **522 Tolna St.** 26-5

5. SEX **M**

6. COLOR OR RACE **White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Wid.**

8. DATE OF BIRTH **Dec. ? ?** 1887

9. AGE (In years last birthday) **61 ?** If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Labour Skilled**

10B. KIND OF BUSINESS OR INDUSTRY **Steel Worker**

11. BIRTHPLACE (State or foreign country) **Roumania**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **?**

14. MOTHER'S MAIDEN NAME **?**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **No**

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. **213-07-0370**

17. INFORMANT **B. C. H. Records, 4940 Eastern Ave.** ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Arteriosclerotic Heart Disease**

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: **6 or 7 yrs.**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **10-28-48**, 19__, *to* **July 27**, 19**49** *that I last saw the deceased alive on* **July 27** 19**49** *and that death occurred at* **2.50PM** *from the causes and on the date stated above.*

23A. SIGNATURE **R. S. Bozeman** M. D.

23B. ADDRESS **4940 Eastern Ave.**

23C. DATE SIGNED **8-2-49**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24B. DATE **8/5/49**

24C. NAME OF CEMETERY OR CREMATORY **Oak Lawn**

24D. LOCATION (City, town, or county) **Baltimore** (State) **Md**

DATE RECEIVED BY LOCAL REGISTRAR **AUG 4 1949**

REGISTRAR'S SIGNATURE **Huntington Williams, M.D.**

25. FUNERAL DIRECTOR **Wilson Cook Inc**

ADDRESS **1217 St Paul St**

VS 150

95d

G76935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

704.1 G76935

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) SEVERN D. BRITTON

2. DATE OF DEATH Aug. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY B2Ho.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 113 Dunkirk Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	11/12/16	32	9	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	S.R. Rosoff	Warren, Md.	USA

13. FATHER'S NAME Roy Britton

14. MOTHER'S MAIDEN NAME Hazel ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WW 2	?	Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Acute myelogenous leukemia	Unknown
DUE TO (B)		
DUE TO (C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Apr. 7, 1949 *to* Aug. 3, 1949, *that I last saw the deceased alive on* Aug. 3 1949 *and that death occurred at* 8:05A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Medical Director M. D.	US Marine Hospital, Balto, Md.	8/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/6/49	Pinelawn Hill Mem	Cockeysville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 4 1949	Municipal Registrar	Wilson Co Dr	1214 Eutaw St

VS 150

74a

G76936 CERTIFICATE CORRECTED 8-9-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No. G76936

1. NAME OF DECEASED (Type or Print) Joseph Lewis

2. DATE OF DEATH 8/3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) So. Bal. Gen. Hospital

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 708 Harvey Street 24-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed Married	July 27 1851	68		7

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Lewis
14. MOTHER'S MAIDEN NAME Mary Lashley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mary Lewis ADDRESS 708 Harvey St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardio-vascular disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/31, 1949 *to* 8/3, 1949 *that I last saw the deceased alive on* 8/3/, 1949, *and that death occurred at* 9:10 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE John W. Bamard M. D.
23B. ADDRESS So. Bal. Gen. Hosp.
23C. DATE SIGNED 8/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 6 1949
24C. NAME OF CEMETERY OR CREMATORY Cedar Hill
24D. LOCATION (City, town, or county) (State) D.C. & Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 4 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR A. Howard Evans ADDRESS 1400 S. Charles St

VS 150

93d

G76937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76937

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Naomi Wollman

2. DATE OF DEATH Aug 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hosp.

C. Length of stay in Baltimore 3 5 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City 2-2
D. STREET ADDRESS (If rural, give location) 233 S Broadway #25

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Hebrew	married	1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Latvia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Not Known

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Son Dr. Jos. Wollman ADDRESS as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal congestive failure c — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO pneumonitis

pyelonephritis ?

(B) Arteriosclerotic cardiovascular

DUE TO disease ?

(C) auricular fibrillation

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Asthenia, cystitis secondary anemia ?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 - 15, 1949 *to* 8 - 3, 1949 *that I last saw the deceased alive on* 8 - 3, 1949 *and that death occurred at* 3:20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Marguerite Louise Cobb, M.D.

23B. ADDRESS Md. General Hosp.

23C. DATE SIGNED 8-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8-7-49

24C. NAME OF CEMETERY OR CREMATORY Rosedale

24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 4 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Lewis Inc

ADDRESS 2100 Eastern Ave

VS 150

93d

G76938

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76938

Registered No.

1. NAME OF DECEASED (Type or Print): JESSE RIGGS LENNOX

2. DATE OF DEATH: 8-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp.

c. Length of stay in Baltimore: 49 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pasadena
D. STREET ADDRESS (If rural, give location): Mt. Pleasant Beach

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	7-13-1872	77		19	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INSTALLER

10B. KIND OF BUSINESS OR INDUSTRY: TELEPHONE Co.

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JESSE LENNOX

14. MOTHER'S MAIDEN NAME: — DEWITT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-10-8965A

17. INFORMANT: JESSE S. LENNOX, SR. ADDRESS: Pasadena, Md. Mt. Pleasant Beach

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Spontaneous pneumo-
DUE TO Thorax

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gastrointestinal, hemorrhage caused ??

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 31, 19 49 *to* Aug 1, 19 49 *that I last saw the deceased alive on* Aug 1, 19 49 *and that death occurred at* 10 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE: A. Andrew Alecce M. D.

23B. ADDRESS: St. Joseph's Hosp.

23C. DATE SIGNED: 8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 8-4-49

24C. NAME OF CEMETERY OR CREMATORY: LOUDON PARK

24D. LOCATION (City, town, or county) (State): FREDERICK RD. BALTO. MD

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: JOHN F. DENNY, INC. ADDRESS: 715 LIGHT ST -30

VS 150

123

1747 Ashland Ave. ✓

G76939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33 1

Registered No. G76939

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ottie Z. Lewis Parham

2. DATE OF DEATH Aug 1st 49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto, Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 57 yrs Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto Md 25
D. STREET ADDRESS (If rural, give location) 1747 Ashland Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Col	married	5-7-92	57 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Washington, D.C.	U.S.A.

13. FATHER'S NAME Richard Lewis

14. MOTHER'S MAIDEN NAME Ida Nelson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Ella Watson	5249 Bond

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 2 days

DUE TO

(B) arterial Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 30 1949 *to* Aug 1st 1949 *that I last saw the deceased alive on* Aug 1 1949 *and that death occurred at* 11 25 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr. J. Edward Fisher M.D.	1612 Monument St	Aug 9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 4/49	Harmony Cemetery	Washington D.C.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Mrs Robert G. Elliott & Daughter

ADDRESS: 1129 N. Carlton

VS 150 AL

83a

CERTIFICATE CORRECTED 8-4-49

G76940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76940

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Daig

2. DATE OF DEATH: Aug. 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1506 N. Patterson Pk Ave

c. Length of stay in Baltimore: 76 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-4
D. STREET ADDRESS (If rural, give location): 1506 N. Patterson Pk. Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Sept. 2 1874	74	11 / 10	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker (Retired)	Bakery	Germany	U.S.A.

13. FATHER'S NAME: Francis Daig

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Mrs. Mary Daig ADDRESS: 1506 N. Pat. Pk

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yrs 4 yrs.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral Arteriosclerosis

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 22 July 1949 *to* 2 Aug 1949, *that I last saw the deceased alive on* 31 July 1949, *and that death occurred at* 6 p *m., from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
Kasan Foreman	1516 N. Milton Ave	4 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-6-49	Holy Redeemer Cem	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 4 1949	Washington Williams, M.D.	Edward W. Conklin	

VS 150

932

G76941

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76941

Registered No.

1. NAME OF DECEASED (Type or Print) CATHERINE, H. SMITH.

2. DATE OF DEATH Aug. 2nd. 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2117-Ramsey St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —
C. Length of stay in Baltimore 60yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) 2117-Ramsey St. 20-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White.	Widowed.	Jan. 26-1879.	70 yrs	6	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife.
10B. KIND OF BUSINESS OR INDUSTRY Own Home.
11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Snyder.
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no. (If yes, give war or dates of service) no.
16. SOCIAL SECURITY NO. no.
17. INFORMANT Mrs. Helen Maben. ADDRESS 1812 Wiehelm St..

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive cardio-vas cular disease — INTERVAL BETWEEN ONSET AND DEATH 14 yrs.
DUE TO
(B)
DUE TO
(C) Diabetes mellitus — 24 yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/1 , 1944, *to* 8/2 , 1949, *that I last saw the deceased alive on* 8/2 , 1949 *and that death occurred at* 11.9 *m., from the causes and on the date stated above.*

23A. SIGNATURE Benjamin Miller MD M. D.
23B. ADDRESS 1030 Wilkens Ave
23C. DATE SIGNED 8/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial.
24B. DATE Aug. 5-49
24C. NAME OF CEMETERY OR CREMATORY London Park Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore - Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 4 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Charles J. Schwab
ADDRESS 3513-Frederick Ave.

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~~76942~~ 2 Copies

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76942

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Eli McNeely

2. DATE OF DEATH: August 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1318 Binder Court 25-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	Widow	June 3 1898	51	1	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME: Archie McNeely
14. MOTHER'S MAIDEN NAME: Ella Tassey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 214-26-2530
17. INFORMANT: Doris McNeely ADDRESS 424

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Kruger M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: August 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): 24B. DATE: Aug 5 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, Town, or county) (State): A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949
REGISTRAR'S SIGNATURE: Hamilton Williams, M.D.

25. FUNERAL DIRECTOR: Robert W. Higgins ADDRESS: 1515 McElderry St

9-d

G76943

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76943

Registered No.

1. NAME OF DECEASED (Type or Print) Catherine Kowakowski

2. DATE OF DEATH Aug 1 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 433 N. Ellwood Ave

C. Length of stay in Baltimore 57 Years Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-1

D. STREET ADDRESS (If rural, give location) 433 N. Ellwood ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Poland	

13. FATHER'S NAME ? Jankowiak

14. MOTHER'S MAIDEN NAME ? Kowakowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Tillie Zyglarski	433 N. Ellwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH 6 mths

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 6th *1949, to* August 1st *1949, that I last saw the deceased alive on* Aug 2nd *1949, and that death occurred at* 1.45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Amelia Link Shepherd M. D.	2211 E Lake Ave	8/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 4/49	Holy Rosary	Balto. County

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 4 1949	Kensington Williams, M.D.	John M. Weber	4014 Gantz

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G76944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76944

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Jennings

2. DATE OF DEATH: Aug. 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Related ?

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Life (Yrs. / Mo. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2540 Orleans St 6-4

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 7-3-80
9. AGE (In years last birthday): 69 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Punch Operator
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Jennings
14. MOTHER'S MAIDEN NAME: Mary Rosenette

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hematomyelia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO Hemangioma of spinal cord
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 7/24/49
19B. MAJOR FINDINGS OF OPERATION: Hemangioma of cord
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/24, 1949 *to* 8/3, 1949, *that I last saw the deceased alive on* 8/3, 1949 *and that death occurred at* 12:05 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Maurice H. Slaw, M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 8-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/6/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cem.
24D. LOCATION (City, town, or county) (State): End of East North Ave

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: Hollins St.

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G76945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76945

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PORTNOI SAMUEL

2. DATE OF DEATH 4 August 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1674 E. Pratt St. 3-1

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M
8. DATE OF BIRTH 1878
9. AGE (In years last birthday) 71 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Michael

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Sophie Portnoi ADDRESS 1676 Pratt St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Edema
DUE TO
(B) Myocardial infarct
DUE TO
(C) A-S heart disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/2, 1949 *to* 8/4, 1949 *that I last saw the deceased alive on* 8/4, 1949, *and that death occurred at* 6:2 a m., *from the causes and on the date stated above.*

23A. SIGNATURE William Krakower M. D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 8/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Funeral
24B. DATE 8-7-49
24C. NAME OF CEMETERY OR CREMATORY Rosedale
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 4 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eutaw Pl

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G76946

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76946

1. NAME OF DECEASED (Type or Print)	ALOYSIUS J. O'MARA, Sr.
2. DATE OF DEATH	8-3-49
3. PLACE OF DEATH: A.	Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	University Hospital
C. Length of stay in Baltimore (Yrs. Mos. Days)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Md.
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	2727 Cylburn Ave. 27-17
5. SEX	M
6. COLOR OR RACE	W
7. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify)	
8. DATE OF BIRTH	Mar. 21, 1882
9. AGE (In years last birthday) / If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.	67 / 4 / 13
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Dining Car Steward
10B. KIND OF BUSINESS OR INDUSTRY	Railroad
11. BIRTHPLACE (State or foreign country)	Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	-
14. MOTHER'S MAIDEN NAME	-
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) / (If yes, give war or dates of service)	male / white
16. SOCIAL SECURITY NO.	
17. INFORMANT / ADDRESS	Mr. Aloysius J. O'Mara, Jr. 2727 Cylburn Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis — DUE TO

ANTECEDENT CAUSES

(B) — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑
7-19-49	Carcinoma of Lung	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-17, 1949 *to* 8-3, 1949, *that I last saw the deceased alive on* 8-3, 1949, *and that death occurred at* 2 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ind Waldrip M. D.	University Hospital	8-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/5/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 4 1949	Kenrington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

472

G769:17 ✓ 550.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C.H-8687 Registered No. G769:17

1. NAME OF DECEASED (Type or Print): GEORGIANA HERRMANN

2. DATE OF DEATH: 8-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1734 ALICEANNA ST. 2-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	SINGLE	8-12-47	1	11	22

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: GEORGE HERRMANN
14. MOTHER'S MAIDEN NAME: AGNES CARIFONIA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Agnes Carifonia ADDRESS: 1734 Aliceanna St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Toxemia; BACTEREMIA Bacteremia?
DUE TO
(B) Ruptured Appendicitis
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: about 60 hours.

19A. DATE OF OPERATION: 8-3-49
19B. MAJOR FINDINGS OF OPERATION: Ruptured Appendix - Minimal Peritonitis
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-3, 1949 to 8-3, 1949, that I last saw the deceased alive on 8-3, 1949, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE: Judith B. Landau M. D.
23B. ADDRESS: Sinai Hospital, Baltimore
23C. DATE SIGNED: 8-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-5-49
24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus Cemetery
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949
REGISTRAR: Huntington for Matthew
25. FUNERAL DIRECTOR: George A. Weber ADDRESS: 705 S. Amity St.

VS 150

121

G76948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

34

Registered No. G76948

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BERNARD WILSON

2. DATE OF DEATH: July 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1925 Harlem Avenue 16-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Demand -	1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home Again -	Self.	Balt. Md	

13. FATHER'S NAME: John Wilson

14. MOTHER'S MAIDEN NAME: Carrie Dodson Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Edema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Acute Congestive Heart Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: [signature] M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: August 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 4, 1949	Baldwin Memorial Methodist	Anne Arundel Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 4 1949	Hunter Williams, M.D.	Earl B. Roberton	403 E. 25th St - Zone 18

VS 151

932

G76949

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G76949 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HENRY DEUSSEN

2. DATE OF DEATH: 8-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — UNION MEMORIAL H.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
C. Length of stay in Baltimore: MANY YEARS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3406 HARFORD Rd. 9-2

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: 12-20-1873
9. AGE (In years last birthday): 75
If Under 1 Year: Months 7, Days 15
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SCHOOL PRINCIPAL
10B. KIND OF BUSINESS OR INDUSTRY: TEACHING - Retired
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: BERNARD DEUSSEN
14. MOTHER'S MAIDEN NAME: CATHERINE ESSER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-22-6663
17. INFORMANT (RELATIONSHIP) ADDRESS: MRS. FERDINAND C SMITH — 934 KANAWHA CITY 18

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CEREBRO-VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 12 days
DUE TO
(B) HCVD & ASHD. — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 27, 1949, to Aug 3, 1949, *that I last saw the deceased alive on* Aug 3, 1949, *and that death occurred at* 12:20 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard R. Beach M. D.
23B. ADDRESS: Union Memorial H.
23C. DATE SIGNED: 8/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): cremation
24B. DATE: 8/5/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.

VS 150

93d BALTIMORE - 13, MARYLAND

G76950 BALTIMORE CITY HEALTH DEPARTMENT G76950

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): FRANK ELMO CARROLL

2. DATE OF DEATH: Aug. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3436 Cliftmont Avenue

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3436 Cliftmont Avenue 26-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	June 10, 1910	39	1	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Control Tower Oper.	U.S. Govt C.A.A.	Michigan	USA

13. FATHER'S NAME: John H. Carroll

14. MOTHER'S MAIDEN NAME: Vernie T. Hinchley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	none	3436 Cliftmont Avenue Mrs. Marie A. Carroll

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

(B) Coronary Thrombosis — few minutes

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1946 *to* August 3, 1949, *that I last saw the deceased alive on* 7-21, 1949, *and that death occurred at* 12 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William L. Fearn M. D.	3025 Belair Road	8-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/8/49	Parkwood Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 4 1949	Carrington Williams, M.D.	Henry Sander & Sons, Inc. BALTIMORE - 13, MD.

VS 150

G76951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76951 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ~~HOWARD~~ HOWARD CLAYTON EDELMANN

2. DATE OF DEATH August 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BaltoCity Hospital (d.o.a.)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Bo Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore, Back River

D. STREET ADDRESS (If rural, give location)
35 E. Riverside Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	May 8, 1888	61	2	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: Morton Outdoor

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles H. Edelmann

14. MOTHER'S MAIDEN NAME: Margaret Hagert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-07-1505

17. INFORMANT Rt. 13 Baltimore ~~ress~~ -21
MRS. LUCILLE EDELMANN

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED August 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/6/49	Oak Lawn Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949

REGISTRAR'S SIGNATURE [signature]

25. FUNERAL DIRECTOR ADDRESS
HENRY SANDER & SONS, INC.

VS 151

931

G76952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76952

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RUBEN SPARKS

2. DATE OF DEATH August 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital (d.o.a.)

c. Length of stay in Baltimore 35 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 14 South Register Street 2-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	Colored	Married	Feb. 27-1893	56	5	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Concert Finisher		Gloster Co. Va	U.S.A.

13. FATHER'S NAME Reuben S Sparks

14. MOTHER'S MAIDEN NAME Mary Francis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Estella Sparks	14 S. Register St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Kopp M.D.		August 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 7-49	Mt Calvery Cem	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
AUG 4 1949	Remitting for Williams, RS	Elroy O. Wilson	1000 Brantly St

OS 191

94a

G76953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76953

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JEREMIAH JOHN CROWLEY

2. DATE OF DEATH Aug. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 110 Dunkirk Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	1/2/92	57	7	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Credit Co.	Mass.	USA

13. FATHER'S NAME Jeremiah Crowley

14. MOTHER'S MAIDEN NAME Margaret Gill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW I	Unknown	Records- US Marine Hospital	Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary sclerosis with occlusion; myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 3, 1949, *to* Aug. 3, 1949, *that I last saw the deceased alive on* Aug. 3, 1949 *and that death occurred at* 9:55A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert D. Dooley Robert D. Dooley, SA Surgeon, U.S.P.H.S.	US Marine Hospital, Balto, Md.	8/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-6-49	New Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 4 1949	Huntington Nottingham, M.D.	John A. Moran	3000 E. Balto. St

VS 150

94a

BIRTH NO. 976951

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 973.0

Registered No. 976954

1. NAME OF DECEASED (Type or Print): Felix McNally Jr. — N-966.0

2. DATE OF DEATH: 8-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — St Joseph Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph Hospital

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 508 McCabe Ave 27-10

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept 24 1901
9. AGE (In years last birthday): 47
If Under 1 Year: Months 10 Days 10
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Felix C. Mc-Nally
14. MOTHER'S MAIDEN NAME: Edara Healy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Marie Mc-Nally — ADDRESS: 508 Mc-Cabe Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carbon monoxide poisoning
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

II
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Erdman Ave., about 100' south of Elmley Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): August 3, 1949 ? p m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Inhalation of auto. exhaust

22. *I certify that I took charge of the remains described above, held an* Inquest *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: ~~natural causes~~ ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

23A. SIGNATURE: C. Hurst McFadden M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 8-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 4 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Old Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John C. Moran — ADDRESS: 3000 Baltimore St

VS 151

163M

G769:55

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G769:55

1. NAME OF DECEASED (Type or Print) HARRY J WISE

2. DATE OF DEATH August 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

C. Length of stay in Baltimore 60 Yrs. 0 Mos. 29 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET-ADDRESS (If rural, give location) 902 S. PACA ST. 21-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
male	white	MARRIED	July 6, 1889	60	0	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TRUCK HAULING	PRODUCE	BALTIMORE MD	US

13. FATHER'S NAME: JOHN WISE

14. MOTHER'S MAIDEN NAME: BRIDGET KERN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		NONE	CLARA G. WISE	902 S PACA ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery disease
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED August 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	AUG-8-49	HOLY CROSS	ANNE ARUNDEL Co MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 4 1949	[signature] Huntington Williams, M.D.	Bernard C Harle	121 E West St

VS 151

94a

G76956 T

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

490

G76956 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Hallie Price

2. DATE OF DEATH Aug. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 908 Little Pine St.

C. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-1
D. STREET ADDRESS (If rural, give location) 908 Little Pine St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Widowed	1886	63.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Balto. Md.	

13. FATHER'S NAME ? Price

14. MOTHER'S MAIDEN NAME Ball

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Lillian Baker	908 Little Pine St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 4 days
DUE TO
(B) none
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 22, 1949 *to* Aug 3, 1949 *that I last saw the deceased alive on* July 31, 1949 *and that death occurred at* 4:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE H. Talbert M. D. | 23B. ADDRESS 632 W Franklin St | 23C. DATE SIGNED Aug 4 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/6/49	Mt Calvary Cemetery	H. A. Co., Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 4 1949 | REGISTRAR'S SIGNATURE Thurlington Williams, M.D. | 25. FUNERAL DIRECTOR W. Halstead | ADDRESS 1708 Pine Ave.

VS 150

G76957

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76957

1. NAME OF DECEASED (Type or Print) JAMES H. GRIMES

2. DATE OF DEATH August 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
C. Length of stay in Baltimore 10 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore, (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 619 N. Calvert Street 11-1

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 21/ 1911
9. AGE (In years last birthday): 38 35 (If Under 1 Year: Months 5, Days 11; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Radio School
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William G Grimes
14. MOTHER'S MAIDEN NAME: Cora Elizabeth Coucil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215 16 3531
17. INFORMANT: Mrs James Grimes ADDRESS: 619 Calvert St Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED August 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. 5 1949
24C. NAME OF CEMETERY OR CREMATORY: Stevensville Cemy
24D. LOCATION (City, town, or county) (State): Stevensville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc.
ADDRESS: 1900 Eutaw Place
94a WMB Mitchell

G76958 ✓ G76958

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

19° Registered No.

1. NAME OF DECEASED (Type or Print): Ella M. Meredith

2. DATE OF DEATH: August 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1536 Linden Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none
C. Length of stay in Baltimore: life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1536 Linden Ave. 14-1

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: May 12, 1862
9. AGE (In years last birthday): 87
If Under 1 Year: Months 2 Days 27
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles P. Meredith

14. MOTHER'S MAIDEN NAME: Katherine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs.R.L.Morgan ADDRESS: 709 Walnut Ave., Balto.29

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema — 2 days
DUE TO
(B) Chronic Arthritis — 1 year
DUE TO
(C) Carcinoma of Brest — ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Senility

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 14, 1949 *to* August 3, 1949, *that I last saw the deceased alive on* August 3, 1949 *and that death occurred at* 5:40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. B. Lever Lowry M. D.
23B. ADDRESS: 1901 Eutaw Place
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 8 - 6 - 49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Place
Mahlon B. Mitchell

VS 150

For Approved medical Examiner: ✓

G76959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 443

G76959

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LOUISA B FARSON

2. DATE OF DEATH Aug. 2, 1948

3. PLACE OF DEATH: A. Baltimore City, Maryland 15 W. MADISON ST.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Md. Gen'l Hosp.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 15 W. Madison St. 11-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Female	White	MARRIED	March 22 1896	52	4	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Maryland	U.S.A.

13. FATHER'S NAME Dr John de C. Butler

14. MOTHER'S MAIDEN NAME Louisa King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	None	Husband.	15 W. Madison St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1-4 hrs

DUE TO (B) Hypertensive Arteriosclerotic cardio-vascular disease — 4-7 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pancreatectomy. Surgical — 3 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1946	Chronic Pancreatitis	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (Give location)

CERTIFICATION APPROVED BY Robert B. McFadden, M.D.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY occur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

CHIEF OR ASST. MEDICAL EXAMINER.

22. *I hereby certify that I attended the deceased from* — 19—, *to* — 19—, *that I last saw the deceased alive on* — 19—, *and that death occurred at* 9:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. C. Martin M. D.	Maryland Gen. Hosp.	8-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	Aug 6-'48	Greenmt	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 4 1949	Registrar Baltimore, Md	Stewart Memorial	Balto.

VS 150

936

G76960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G76960

1. NAME OF DECEASED (Type or Print): Mr. Alfonso von Wyszecki

2. DATE OF DEATH: August 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

c. Length of stay in Baltimore: 4 da. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Co. Md.
D. STREET ADDRESS (If rural, give location): Glen Arm P.O. Balto. Co. Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	9/16/65	~~83~~	10	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LAWYER	Law	GERMANY	U.S.

13. FATHER'S NAME: Oscar von Wyszecki

14. MOTHER'S MAIDEN NAME: Antoinette von Rozewicz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	NONE	Mrs. B. Goutreau (Daughter)	Kingsville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Cardiac Failure.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B) Congestive Heart Failure.
DUE TO
(C) Heart Block.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 30th 1949 *to* August 3 1949, *that I last saw the deceased alive on* August 3 1949, *and that death occurred at* 1.45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Carlos J. Castellano M. D. | 23B. ADDRESS: Bon Secours Hosp. | 23C. DATE SIGNED: August 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Aug-3/49 | 24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge | 24D. LOCATION (City, town, or county) (State): Pikesville

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Stewart & Mercer Co. | ADDRESS: Balto.

VS 150

932

76961 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

17° 076961 Registered No.

1. NAME OF DECEASED (Type or Print): Mattie Riggs Campbell
2. DATE OF DEATH: Aug-3-49
3. PLACE OF DEATH: A. Baltimore City, Maryland 408 Britton Pl.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home
c. Length of stay in Baltimore: Yrs. Life Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 408 Britton Pl 12-1
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Dec-18-1871
9. AGE (In years last birthday): 77yr
If Under 1 Year: Months 7 Days 15
If Under 24 Hours: Hours — Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joshua W. Riggs
14. MOTHER'S MAIDEN NAME: Mattie B Dorsey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
16. (If yes, give war or dates of service): No
17. SOCIAL SECURITY NO.: NONE
INFORMANT: Mrs Evelyn R. Potter (daughter) ADDRESS: Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of breast (left) with generalized metastasis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: aug. 1947
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of left breast
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1947 to aug. 3, 1949, that I last saw the deceased alive on aug. 2, 1949, and that death occurred at 1:30 A m., from the causes and on the date stated above.

23A. SIGNATURE: Lloyd E. Taylor M. D.
23B. ADDRESS: 3902 Greenmount Ave.
23C. DATE SIGNED: aug. 3/1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug-4-49
24C. NAME OF CEMETERY OR CREMATORY: Green Mount
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: AUG 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
26. FUNERAL DIRECTOR: Stewart-Moore Co.
ADDRESS: Balto.

VS 150

1050

G76962

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-01

G76962

Registered No.

1. NAME OF DECEASED (Type or Print) EMIL E. LAUER

2. DATE OF DEATH August 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 3604 Elmley Ave. 26-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Divorced	Nov. 6, 1916	32				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Baltimore	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Alphonso	Elizabeth Dulin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Elizabeth Jacoby 3604 Elmley Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Royer M.D.		August 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/5/49	Oak Lawn Eastern	7225 Eastern Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 4 1949	Huntington Williams, M.D.	Clarence F. Hoffmann 1639 Broadway.

VS 151

94a

G76963

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157 G76963

Registered No.

1. NAME OF DECEASED (Type or Print): Vogler, John Henry

2. DATE OF DEATH: August 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3801 Hudson Street 26-9

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Feb. 2, 1897	52	5 / 30	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician	Own Business	Baltimore, Maryland	

13. FATHER'S NAME: John Vogler

14. MOTHER'S MAIDEN NAME: Wilhelmenia Kline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Marie M. Vogler 3801 Hudson St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying; e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bile Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Coccinaea, Head of Pancreas — —

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-30-49 7-06-49	Choledochoduodenostomy Cholecystectomy; Choledocostomy.	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 27, 1949, *to* August 1, 1949, *that I last saw the deceased alive on* Aug. 1, 1949, *and that death occurred at* 2:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James R. O'Hare M. D.	21 S. Eutaw St.	Aug. 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/5/49	Parkwood	Taylor Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
AUG 4 1949	Huntington Williams, M.D.	Clarence F. Hoffmann 1639 Broadway.

VS 150

469.

G76964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76964

BIRTH NO. Edgar

1. NAME OF DECEASED (Type or Print) Edmund? Mannine

2. DATE OF DEATH August 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Dorchester
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hurlock HURLOCK
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		8-27-11	37		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver		Md.	

13. FATHER'S NAME Warmey Mannine

14. MOTHER'S MAIDEN NAME Zonetta Turners

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S ADDRESS
	223-09-5065	JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

(B) Tuberculous pericarditis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-13, 1949 *to* 8-3, 1949 *that I last saw the deceased alive on* 8-3, 1949 *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip S. Hagley M. D.	JOHNS HOPKINS HOSPITAL	8-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	Aug 5 1949	East New Market	East New Market

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 4 1949	Tuntayton Williams, MD	J. B. Tillough	Hurlock Md

VS 150

G769:5

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G769:5

1. NAME OF DECEASED (Type or Print): Mettie Doris

2. DATE OF DEATH: 8/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3708 Hayward Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3708 Hayward Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	June 28, 1868	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	near Grafton, W. Va.	U. S. A.

13. FATHER'S NAME: John Riley

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
—	—	Mrs. Lester Trout-3708 Hayward Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Chr. Myocarditis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 2, 1949, *to* Aug 4, 1949, *that I last saw the deceased alive on* Aug 3, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. E. Shannon M. D.	820 Medical Arts Bldg.	Aug 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/6/49	Doris Cem.	Doris, W. Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
AUG 5 1949	Huntington Williams, M.D.	Loring Byers 500 Pk Highlandtown

VS 150

93D

File 129746 — G76966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Christine Woods	2. DATE OF DEATH: 8-3-49
3. PLACE OF DEATH: A. Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
c. Length of stay in Baltimore: Yrs. 1 Mos. Life Days	D. STREET ADDRESS (If rural, give location): 6525 St. Helena Ave. -22
5. SEX: F	6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Nov. 20, 1900
9. AGE (In years last birthday): 48	If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Frederick Crate	14. MOTHER'S MAIDEN NAME: Anna Link
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT: B. C. H. Records, 4940 Eastern Ave.	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Syphilitic Arachnoiditis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 17, 1949 *to* Aug. 3, 1949 *that I last saw the deceased alive on* Aug. 3, 1949, *and that death occurred at* 9.15 PM *from the causes and on the date stated above.*

23A. SIGNATURE: J. S. Bozeu M. D.	23B. ADDRESS: 4940 Eastern Ave.	23C. DATE SIGNED: 8-4-49
24A. BURIAL, CREMATION, REMOVAL (Specify): Burial	24B. DATE: 8/6/49	24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Baltimore Md		
DATE RECEIVED BY LOCAL REGISTRAR: AUG 5 1949	REGISTRAR'S SIGNATURE: Huntington Williams, M.D.	25. FUNERAL DIRECTOR: Waltham C. H. Inc ADDRESS: 1217 E. Baltimore St.

VS 150

30 C

G76967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G76967

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): BERTHA PACE

2. DATE OF DEATH: August 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3532 Park Heights Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 3532 Park Heights Avenue 15-17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	May 4, 1861	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore Md	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Mrs C A Myers, ADDRESS: 3532 Park Heights Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Wallace J. McClafferty M.D.	☐ / ☒ / ☐	August 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/8/49	London Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Huntington Williams, M.D.	Wilson & Son Inc	1217 E. Oval St

VS 151

935

CERTIFICATE CORRECTED 8-9-49 ✓ V.O.1

G76968

G76968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76968

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Fowler, George

2. DATE OF DEATH: Aug 2. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore Gen Hosp
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2449 Westport St 25-33

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: March 9. 1909
9. AGE (If under 1 year, last birthday) — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.: 39 40
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brown Humphreys
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Capitol Heights Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Robert C Fowler
14. MOTHER'S MAIDEN NAME: Margaret L Fowler
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Melvin H Fowler Sr. ADDRESS: 2449 Westport St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO
(B) due to
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Splenic abscess, etiology (?)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Myocardial Infarction due to Atherosclerosis of coronary artery — old

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-1 1949 *to* 8-2 1949 *that I last saw the deceased alive on* 8-2 1949 *and that death occurred at* 1 15 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Marvin D. Davis M. D.
23B. ADDRESS: West Baltimore General
23C. DATE SIGNED: 8-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/6/49
24C. NAME OF CEMETERY OR CREMATORY: Forestville Methodist
24D. LOCATION (City, town, or county) (State): Forestville Md
25. FUNERAL DIRECTOR: William E. Davis ADDRESS: 1217 Hood St.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

VS 150

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G76969 BALTIMORE CITY HEALTH DEPARTMENT G76969

BIRTH NO. B.C. 49 15274 CERTIFICATE OF DEATH 761 Registered No.

1. NAME OF DECEASED (Type or Print) BABY BOY Quinn — 2. DATE OF DEATH 7-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKlin Square Hosp.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — B. COUNTY
146 Lanvale St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balt. Md 20-07
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	SINGLE	7-26-49				11	18

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	U.S.

13. FATHER'S NAME: E. A. Quinn
14. MOTHER'S MAIDEN NAME: Ida Eisert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		CHART	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Asphyxia~~ Subarachnoid Hemorrhy — INTERVAL BETWEEN ONSET AND DEATH 11 hrs Ra
DUE TO
(B) Premature LABOR
DUE TO
(C) separation of Low implanted placenta.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7-26 1949, *to* 7-27 1949, *that I last saw the deceased alive on* 7-27, 1949, *and that death occurred at* 8:30 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter K. Shelberg M. D.	Franklin Sq. Hosp	8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
		UNIVERSITY MEDICAL SCHOOL	AUG 1 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

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G76970

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

Registered No. G76970

1. NAME OF DECEASED (Type or Print): Blanche Robinson

2. DATE OF DEATH: Aug 3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1106 argyle ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

C. Length of stay in Baltimore: Life (Yrs. / Mon. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 1106 argyle ave
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 17-ward
D. STREET ADDRESS (If rural, give location): 1106 argyle ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Female	Colored	married	Sept 3-1892	56	11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Balto

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Stephen Scott

14. MOTHER'S MAIDEN NAME: alvarda Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no

(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Charles Robinson ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 7-20-49

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-20, 1949 *to* 8-0, 1949 *that I last saw the deceased alive on* 8-3, 1949 *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles F. Martin M. D.	917 Cathedral St	8-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Aug 7-49	Mt. Auburn	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Tunstall Williams, M.D.	James A. Hayes	142 N. Fiel St

VS 150

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ES-130658

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. G76971 B.C. 49-1769 **CERTIFICATE OF DEATH** 776 Registered No. G76971

1. NAME OF DECEASED (Type or Print): Baby Boy Hill

2. DATE OF DEATH: 7-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1738 Orleans Street. 6-05

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 7-28-49
9. AGE (In years last birthday): If Under 1 Year — Months: — Days: 2 — If Under 24 Hours — Hours: — Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Ruth Hill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
16. (If yes, give war or dates of service):
SOCIAL SECURITY NO.:

17. INFORMANT: RECORDS BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-28, 1949 *to* 7-30, 1949, *that I last saw the deceased alive on* 7-30 1949, *and that death occurred at* 10:15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 8-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 9:00 A.M. 8-2-49
24C. NAME OF CEMETERY OR CREMATORY: B.C.H.
24D. LOCATION (City, town, or county) (State): 4940 Eastern Avenue ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: AUG 5 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR

VS 150

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G76972

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76972

1. NAME OF DECEASED (Type or Print)	RANDOLPH EVERETT BELL
2. DATE OF DEATH	4 Aug 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Florida, B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Miami
c. Length of stay in Baltimore — Yrs. Mos. Days	D. STREET ADDRESS (If rural, give location) 590 Island Road - Bay Point

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Married	Nov. 4 1892	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
lawyer	no	Massachusetts (Attleboro Falls)	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William H. Bell	Eudora Briggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	World War I/1917-18	none	Mrs Randolph E. Bell.	same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — (A) Pulmonary hemorrhage, bilateral.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Subdural hemorrhage, bilateral — DUE TO

(C) acute aleukemic myeloid leukemia.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — Renal infarct, left

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 24 June, 1949, *to* 4 Aug, 1949, *that I last saw the deceased alive on* 4 Aug, 1949, *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles N. Watts M. D.	Union Memorial Hospital	8/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	8/5/49	Attleboro,	Attleboro, Mass.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

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G76973

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76973

1. NAME OF DECEASED (Type or Print): Edgar D. Shrodes

2. DATE OF DEATH: Aug 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2636 Guilford Ave.
c. Length of stay in Baltimore: 29 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2636 Guilford Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last Birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
M	W	M	May 2, 1883	66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Signalman
10B. KIND OF BUSINESS OR INDUSTRY: B & O R.R.
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James W. Shrodes
14. MOTHER'S MAIDEN NAME: Mary Robey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Ethel L. Shrodes ADDRESS: 2636 Guilford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Thrombosis	18 days
DUE TO	(B) Generalized Arteriosclerosis	3 yrs +
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	(C) Cerebral Thrombosis Multiple	3 yrs —
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Bronchopneumonia Rt. Lower Lobe	8 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1946 *to* Aug 3, 1949, *that I last saw the deceased alive on* Aug 3, 1949, *and that death occurred at* 11:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Samuel T. R. Revell, Jr. M. D.
23B. ADDRESS: 11 E. Chase St.
23C. DATE SIGNED: Aug 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Augst 6-1949
24C. NAME OF CEMETERY OR CREMATORY: Mount Olivet
24D. LOCATION (City, town or county) (State): Baltimore, Maryland

DATE RECEIVED LOCAL REGISTRAR: AUG 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Burgee Funeral Home
ADDRESS: 3631 Pulaski Road

VS 150

43B

G76974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

'51

G76974

Registered No.

BIRTH NO. B.C. 49-14350

1. NAME OF DECEASED (Type or Print): Paul Dennis Crawford

2. DATE OF DEATH: 8/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: 20 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4031 Edgewood Rd. 15-11

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Infant
8. DATE OF BIRTH: 7/14/49
9. AGE (In years last birthday) If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.: 20 days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Paul
14. MOTHER'S MAIDEN NAME: Joan O'Henlin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Infected myelomeningocele
DUE TO
(B)
DUE TO
(C)

II ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 14, 1949 *to* August 3, 1949 *that I last saw the deceased alive on* August 3, 1949, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Hubert J. Kenilas M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 8/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/5/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: AUG 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: M. Fahey & Sons
ADDRESS: 1827 W. North Ave

VS 150

157B

076975

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 076975

1. NAME OF DECEASED (Type or Print): Henry Logan

2. DATE OF DEATH: Aug. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2416 Madison Ave. 13-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	married	March 16, 1900	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Porter		Georgia	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frederick Logan	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Mary Logan Logan	2416 Madison Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculous meningitis
DUE TO
(B) Pulmonary Tuberculosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 15, 1949, to Aug 4, 1949 *that I last saw the deceased alive on* Aug 4, 1949, *and that death occurred at* 2:25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr. H. L. McCulloch M. D.	Community Hospital	Aug 4 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-7-49	Robertson Mem.	Balto. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Evelyn Williams M.D.	Wm. H. Frames A. Hensley & W. Fidd Wm	578

VS 150

13B

G76976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76976

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Susie Jackson

2. DATE OF DEATH: August 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 709 N. Carey Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Mafyland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 709 N. Carey Street 16-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	Colored	Married	March 23, 1888	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U. S. A.

13. FATHER'S NAME: John A. Locks

14. MOTHER'S MAIDEN NAME: Elender Spriggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. Jno. F. Jackson	709 N. Carey St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: about 24 hrs.

DUE TO

(B) Acute Circumscribed Myocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 31st, 1945, *to* Aug. 3rd, 1949 *that I last saw the deceased alive on* Aug 3rd 1949 *and that death occurred at* 11.45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. M. Lawrence — M. D.	1033 W. Lanvale St.	8-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-7-49	Brook's Chapel	Mutual, Calvert Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Huntington Williams, M.D.	M's Frances A. Hemsley	578 W. Biddle

VS.150

94a

G76977

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

581.0 ✓

Registered No. G76977

1. NAME OF DECEASED (Type or Print): John Thomas Hampshire

2. DATE OF DEATH: 8/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto City Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md. Genl Hosp.

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3210 Keswick Road 13-05

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married.
8. DATE OF BIRTH: Sept 4 1879
9. AGE (In years last birthday): 69
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Hampshire
14. MOTHER'S MAIDEN NAME: Mary Bull

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary L. Hampshire ADDRESS: 3210 Keswick Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Hepatic Failure
DUE TO
(B) Cirrhosis of Liver.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 7/29/49
19B. MAJOR FINDINGS OF OPERATION: Ascites

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/25 *, 1949 to* 8/3 *, 1949 that I last saw the deceased alive on* 8/3 *, 1949, and that death occurred at* 11:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: E. C. Cerrano M. D.
23B. ADDRESS: Md. Genl Hosp
23C. DATE SIGNED: 8/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 6/49
24C. NAME OF CEMETERY OR CREMATORY: West Liberty
24D. LOCATION (City, town, or county) (State): Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Austin E. Donovan
ADDRESS: 3818 Poland Ave

VS 150

124B

G76978

ES-130554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76978

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Marie Escudero or Marie Serena

2. DATE OF DEATH: 8-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 230 Herring Ct. (2)

3-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Wid.	11-21-1894	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Jordon
14. MOTHER'S MAIDEN NAME: Margaret Lutz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Thrombosis — Interval between onset and death: 2 Weeks

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes Mellitus

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-25 19 49 *to* 8-3- 19 49 *that I last saw the deceased alive on* 8-3- 19 49 *and that death occurred at* 8:45 A *m from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 8-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 6 1949
24C. NAME OF CEMETERY OR CREMATORY: Swartz Cemetery
24D. LOCATION (City, town, or county) (State): 6115 O'Donnel St Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 5 vs 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: Offal Bros. ADDRESS: 1800 E Lombard street

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G76979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76979

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ida Katherine Anthony

2. DATE OF DEATH Aug. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 821 W. Barre St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 821 W. Barre St. 21-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowdd	July 17, 1876	73 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Baltimore, Md.	

13. FATHER'S NAME: Charles Schlueter

14. MOTHER'S MAIDEN NAME: Christina Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Mrs. Ida L. Seifert	821 W. Barre St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

16. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Decompensating Heart Disease 2 Mo.
DUE TO
(B) Arteriosclerosis, Generalized Indet.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
*DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Lymphocytic Leukemia 8 yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1948 *to* August 3, 1949 *that I last saw the deceased alive on* Aug 2, 1949, *and that death occurred at* 10:20 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A Bradley Longhurst M. D.	2033 W. North Ave	8/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/5/49	Baltimore National	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

74a

~~G76980~~ Pr. Haase

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76980

1. NAME OF DECEASED (Type or Print): Josephine Tworek

2. DATE OF DEATH: Aug, 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2831 Montebello Terrace

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2831 Montebello Terrace 77-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	widowed	Feb. 28, 1876	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Poland	

13. FATHER'S NAME: Theodore Andrush

14. MOTHER'S MAIDEN NAME: Josephine Ksziuk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. H. Nagornowski	2831 Montebello Terrace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uraemia
DUE TO
(B) Obstruct: C.U.D.
DUE TO
(C) Carcinoma of cervix & metastasis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
March 1949	Carcinoma of cervix & metastasis bladder	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. , 1949 *to* Aug. 3 , 1949, *that I last saw the deceased alive on* Aug. 3 , 1949, *and that death occurred at* 7:15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. H. Hasse M. D. M. D.	4218 Harford Rd	8/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-6-49	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Hunter for Williams, M.D.	Leonard J. Ruck,	5305 Harford Road.

VS 150

48a

G76981

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76981

1. NAME OF DECEASED (Type or Print) PATRICK J. DUGGAN

2. DATE OF DEATH 8/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3110 Keaver Ave

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-01
D. STREET ADDRESS (If rural, give location) 3110 Keaver Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	Nov. 1-1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ireland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Joseph L. Duggan - ADDRESS 3110 Keaver Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONORY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH 8/4/49

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) MYOCARDIAL INSUFFICIENCY 1947

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

CERTIFICATION APPROVED BY
Earl L. Royer M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/4/49, 19__, *to* 8/4/49, 19__, *that I last saw the deceased alive on* —, 19__, *and that death occurred at* 5:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Walter E. Karsner M. D.

23B. ADDRESS 4531 Harford Rd

23C. DATE SIGNED 8/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried

24B. DATE 8/6/49

24C. NAME OF CEMETERY OR CREMATORY New Cathedral

24D. LOCATION (City, town, or county) (State) Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 5 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Leonard J. Luck ADDRESS 5305 Harford Rd

VS 150

94a

G76982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1 53

Registered No. G76982

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Walter S.Gill**

2. DATE OF DEATH **Aug.3rd.,1949**

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **1215 E.Federal Street**

C. Length of stay in Baltimore — Yrs. **Life** Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY **City**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore City**

D. STREET ADDRESS (If rural, give location) **1215 E.Federal Street** 9-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	**White**	**Widowed**	**9-18-1873**	**75**	**10**	**16**	**##**	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stationary Engineer	**Gas Company**	**Baltimore,Maryland**	**U.S.A.**

13. FATHER'S NAME **John C.Gill**

14. MOTHER'S MAIDEN NAME **( ) Jones**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	**None**	**212-05-6112**	**Charles A.Gill,1215 E.Federal Street**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Carcinoma of colon** — INTERVAL BETWEEN ONSET AND DEATH: **10 mos.**

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. **Arteriosclerotic cardio-vascular disease** **7 years**

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* **Jan.** 1949 *to* **Aug.3,** 1949 *that I last saw the deceased alive on* **Aug.2** 1949, *and that death occurred at* **3:40** *p.m., from the causes and on the date stated above.*

23A. SIGNATURE, M. D.	23B. ADDRESS	23C. DATE SIGNED
William H. Frenzer	**1402 E. Lanvale St.**	**Aug.4 49**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**8-6-49**	**Most Holy Redeemer**	**Belair Rd.Balto:Md.**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 5 1949	**Huntington Williams, M.D.**	**George J.Ruth,Inc. 1735 Harford Avenue**

VS 150

46E

G76983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59

G76983 Registered No.

BIRTH NO. B.C. 49-15919

1. NAME OF DECEASED (Type or Print): Baby Boy Johnson

2. DATE OF DEATH: Aug. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. for Women of Md.

c. Length of stay in Baltimore: ~~Years~~ ~~Months~~ 1 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12 27-09
D. STREET ADDRESS (If rural, give location): 4645 Marble Hall Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	single	Aug 1, 1949				1	10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	—	Maryland	USA

13. FATHER'S NAME: Phillip Standiford Johnson

14. MOTHER'S MAIDEN NAME: Dorothy Van Bibber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			Dorothy Van Bibber Johnson	

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Congenital absence of left diaphragm	1h 10m
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 1, 1949 *to* Aug 1, 1949 *that I last saw the deceased alive on* Aug 1, 1949 *and that death occurred at* 6:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William G. Spencer, Jr. M.D.	Hosp. for Women of Md.	8-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		JOHN HOPKINS MEDICAL SCHOOL	AUG 3 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

157M

G76984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

76 G76984

Registered No.

BIRTH NO. B.C. 49-15554

1. NAME OF DECEASED (Type or Print): Baby Boy BROWN - Twin #1

2. DATE OF DEATH: 7/31/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore Genl. Hospital.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2622 Hofer Street. 20-04

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 7-30-49
9. AGE (In years last birthday): If Under 1 Year — Months: 0 Days: 0; If Under 24 Hours — Hours: 17 Min.: 43

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Edward Francis Brown
14. MOTHER'S MAIDEN NAME: Clara Virginia Zachman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.

17. INFORMANT: Mother — ADDRESS: 2622 Hofer

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Immaturity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-30, 1949 *to* 7-31, 1949 *that I last saw the deceased alive on* 7-31, 1949, *and that death occurred at* 8:01 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sara E. Bennett M. D.
23B. ADDRESS: West Baltimore Genl Hosp.
23C. DATE SIGNED: 7/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: JOHNS HOPKINS MEDICAL SCHOOL AUG 3 1949
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: AUG 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 150

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Please write this copy. Do not use typewriter. Physician: please complete items 18 to 22 inclusive. Do not sign certificate until entire certificate is complete.

G76985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-15555

Registered No. G76985

1. NAME OF DECEASED (Type or Print): Baby Boy Brown - Twin #2

2. DATE OF DEATH: 7-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore Gen. Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2622 Hofer St. 20-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	SINGLE	7-30-49		0	0	16	0

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Francis Brown
14. MOTHER'S MAIDEN NAME: Clara Virginia Zachman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mother ADDRESS: 2622 Hofer St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Immaturity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [Y] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-30, 1949 *to* 7-31, 1949 *that I last saw the deceased alive on* 7-31 1949 *and that death occurred at* 6 22 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: James L. Gray M. D.
23B. ADDRESS: West Baltimore Gen. Hosp.
23C. DATE SIGNED: 7-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL AUG 3 1949
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: AUG 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 150

159

CERTIFICATE CORRECTED

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

76986 BIRTH NO.

G76986 Registered No.

1. NAME OF DECEASED (Type or Print) WILLIAM B. THOMPSON JR.

2. DATE OF DEATH August 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New York
B. COUNTY
C. CITY OR TOWN New York
D. STREET ADDRESS (If rural, give location) 432 St. Nicholas Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	colored	Married	May 16, 1907	42 35				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
~~Property & Supply Clerk~~

10B. KIND OF BUSINESS OR INDUSTRY
U. S. Treasury Dept.

11. BIRTHPLACE (State or foreign country) Valley Lee

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME
William B. Thompson

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

10. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture dislocation of cervical spine c transection of cord

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ ~~CAUSE OF~~ DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Route # 246, 1½ miles east of Great Mills,

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 30, 1949 9 p. m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? St. Mary's Co? Auto skidded off road (passenger)

22. *I certify that I took charge of the remains described above, held an* ~~inquest~~ Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L. Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED August 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/8/49

24C. NAME OF CEMETERY OR CREMATORY St. Mark's

24D. LOCATION (City, town or county) (State) Valley Lee, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 5 1949

REGISTRAR'S SIGNATURE Washington Williams, M.D.

25. FUNERAL DIRECTOR Jos. L. Mattingley

ADDRESS Leonardtown, Md.

VS 151

170c

G76987

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76987

1. NAME OF DECEASED (Type or Print): Henry H. Schleman

2. DATE OF DEATH: 8/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 7111 Harford Road 27-05

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: January 8
9. AGE (In years last birthday): 80 — If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Funeral Director
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Ernest Schleman
14. MOTHER'S MAIDEN NAME: Margaret Middlekamp.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS: So. Balto. Gen. Hosp. Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) CORONARY ARTERY OCCLUSION
DUE TO
(C) GENERALIZED ARTERIOSCLEROSIS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/31, 1949 *to* 8/4, 1949, *that I last saw the deceased alive on* 8/4, 1949, *and that death occurred at* 10:46 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Samuel P. Scalia M. D.
23B. ADDRESS: 1213 Light Street
23C. DATE SIGNED: 8/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried.
24B. DATE: 8/8/49
24C. NAME OF CEMETERY OR CREMATORY: Western
24D. LOCATION (City, town, or county) (State): Balto. City.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR — ADDRESS: C. J. Keaman 4611 Park Hgts.

VS 150

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G76988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1 G76988

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John W. Glover

2. DATE OF DEATH Aug. 4-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 815 S. Potomac St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

C. Length of stay in Baltimore 86 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 815 S. Potomac St 1-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	Nov. 18-1862	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sta. Engineer	?	Baltimore Md	U.S.

13. FATHER'S NAME Thomas Glover

14. MOTHER'S MAIDEN NAME Sarah Glover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. none

17. INFORMANT Mrs. I. King ADDRESS 815 S Potomac St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: July 10 & 4 9

DUE TO

(B) Chr. arterio Sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 10, 1949, to Aug 4, 1949 *that I last saw the deceased alive on* Aug 3, 1949, *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. J. Davidow M. D.	3218 Eastern Ave	8-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 6-49	Oak Lawn	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5, 1949	Huntington Williams, M.D.	John J. Dunbar	3829 Hudson St

FS 150

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To correct any of the above items is especially important. Physician please write the cause of death clearly and legibly.

G76989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76989

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ignatius V. Svarovsky

2. DATE OF DEATH 8-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2422 E. Federal st

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-03
D. STREET ADDRESS (If rural, give location) 2422 E. Federal Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	July 2, 1881	68 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY: Barber

11. BIRTHPLACE (State or foreign country): Austria Hungary

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Julia E. Svarovsky ADDRESS: 2422 E. Federal St.

MEDICAL CERTIFICATION

Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Coronary sclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 2 1949 to Aug 4 1949, that I last saw the deceased alive on Aug 3 1949, and that death occurred at 1:45 pm, from the causes and on the date stated above.

23A. SIGNATURE: Frederick Linda M. D.

23B. ADDRESS: 1000 N. Wolfe St. Balto 5 Md

23C. DATE SIGNED: 8-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 8-8-49

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Belair Road

DATE RECEIVED BY LOCAL REGISTRAR: AUG 9 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John C. Millender ADDRESS: 2435 E. Oliver St.

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G76990 ✓ G76990

BALTIMORE CITY HEALTH DEPARTMENT 443

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MUELLER, JOHN

2. DATE OF DEATH 8-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSP.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 702 McCabe St. 27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	White	married	April 1, 1880	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Brewer	National Brewery	Germany	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Phillip Moeller	Krueger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
unknown	218-07-0039	

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO Hypertension & Myocarditis	
ANTECEDENT CAUSES	(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8/2/49	Bet at Leg Herpes	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/1/49 *, 19* 49 *to* 8/4 *, 19* 49 *, that I last saw the deceased alive on* 8/4 *, 19* 49 *, and that death occurred at* 9:15 *m. from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm F Carlisle M. D.	9 E Lexington St	8/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	Aug 6 / 49	Green Mount	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Huntington Williams, M.D.	Henry W Jenkins & Sons	4905 York Rd.

VS 150

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Please print or type the cause of death clearly and legibly. Report exact age if a child is under one year. Physician, please write in ink.

G76991 ✓ 5-9 ✓ G76991

BIRTH NO. G76991

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) ALFREDINE E. FRAME

2. DATE OF DEATH 8/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTO. GEN. HOSPITAL

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 105 S. MONROE ST. 19-04

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH FEB. 2 1891
9. AGE (In years last birthday) 58
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME LAURIAULT
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS MR. J. WALLACE FRAME - 105 S. MONROE ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CHRONIC NEPHRITIS
DUE TO
(B)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
ATELECTASIS - BILATERAL
DIABETES MELLITUS

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/1/49 *to* 8/4/49 *that I last saw the deceased alive on* 8/3, 1949 *and that death occurred at* 1:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Lillian Woodruff M. D.
23B. ADDRESS W Balto
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE AUG. 6 '49
24C. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE
24D. LOCATION (City, town, or county) (State) DORSEY, MD

DATE RECEIVED BY LOCAL REGISTRAR AUG 5 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR Harry H Witzke
ADDRESS 4101 EDMONDSON AVE

VS 150

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BIRTH NO. G76992

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G76992

1. NAME OF DECEASED (Type or Print): Logan, John

2. DATE OF DEATH: 8-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. Geriatric Hosp.

C. Length of stay in Baltimore: 40 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 28-01
D. STREET ADDRESS (If rural, give location): 4202 Elderon Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M		80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt.

10B. KIND OF BUSINESS OR INDUSTRY: Volunteers of America Hosp.

11. BIRTHPLACE (State or foreign country): Canada

12. CITIZEN OF WHAT COUNTRY? U.S. of A.

13. FATHER'S NAME: John Logan

14. MOTHER'S MAIDEN NAME: Mc Intyre

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Ruth Logan ADDRESS: 4202 Elderon Ave

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician please write important. Especially contact age is especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction
DUE TO (a) acute and (b) old

INTERVAL BETWEEN ONSET AND DEATH: Several hrs / days (about 3)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-26 19 49 *to* 8-3 19 49, *that I last saw the deceased alive on* 8-3 19 49, *and that death occurred at* 9 45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marie 92. Dani M. D. | 23B. ADDRESS: West Balto Geriatric Hosp | 23C. DATE SIGNED: 8-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): | 24B. DATE: Aug. 6 49 | 24C. NAME OF CEMETERY OR CREMATORY: Herald Ridge | 24D. LOCATION (City, town, or county) (State): Catonsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 5 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Harry A. Leitzke | ADDRESS: 4101 Edmondson Ave.

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G76993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

G76993

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles W Collier

2. DATE OF DEATH August 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
27 N. CAREY ST
Good Samaritan Nursing Home

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 20 07
D. STREET ADDRESS (If rural, give location) 149 PALORMO AVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	MARRIED	NOV. 14 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		WEST VIRGINIA	

13. FATHER'S NAME
FREDERICK COLLIER

14. MOTHER'S MAIDEN NAME
ALMA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS
MRS CHARLES COLLIER - 149 PALORMO AVE

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician's special attention is important. Correct age is especially important.

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemiplegia Right Side — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
DUE TO
(B) Cerebral hemorrhage — 3 yrs Aug 3, 1949
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic Myocarditis + Myocardial degeneration?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 14, 1948, *to* August 4, 1949, *that I last saw the deceased alive on* August 3, 1949, *and that death occurred at* 4:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Melvin N. Borden M. D.	2030 W. Fayette St	8/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	AUG 8 1949	MT OLIVET	FREDERICK, MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Tumbleston Williams, M.D.	Harry A Wetzler	1101 Edmondson Ave

937

G76994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E816.5

G76994

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) HAROLD QUINZER

N-829.0

2. DATE OF DEATH August 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hoppital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore County
D. STREET ADDRESS (If rural, give location) 1806 Lochshield Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	MARRIED	March 19-1907	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	AUTO	MASS.	

13. FATHER'S NAME
HARRY Quenzer

14. MOTHER'S MAIDEN NAME
Rose C. Coughlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Harold A. Quenzer	1806 Lochshield Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Multiple fractures	
DUE TO		
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Public	63-00 Wash. Blvd., 2 miles south of Waterloo

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 3, 1949 Approx. 6 p. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	State Police Barr. Auto. and Bus and Tractor-Trailer Col.

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
M.D.		August 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-6-49	New Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Huntington Williams, M.D.	John A. Moran	3000 Falls St

VS 191

170c

correct age is especially important. Physicians please write the cause of death clearly and legibly.

G76995
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163 G76995
Registered No.

1. NAME OF DECEASED (Type or Print): Mary Brining
2. DATE OF DEATH: Aug 5 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Shayne
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Finneytown
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white		6-29-79	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housework	own home	Md	U.S.A.

13. FATHER'S NAME: Benton Brining
14. MOTHER'S MAIDEN NAME: Clara Mc Kellip

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of rt. lower branches	1yr±
ANTECEDENT CAUSES	DUE TO (B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7/29/49 *to* 8/5/49, *that I last saw the deceased alive on* 8/2/49, *and that death occurred at* 7:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert M. Paine M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 8 1949	Lutheran Cemetery	Finneytown, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Huntington Williams, MD	C. O. Russ Son	Finneytown, Md.

VS 150

47c

Please write the cause of death clearly and legibly. Physician's special age is especially important.

G76996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G76996

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES ARTHUR HALL

2. DATE OF DEATH Aug. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2808 Remington Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	col	Single	10/17/02	47				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student		Md.	USA

13. FATHER'S NAME George Hall

14. MOTHER'S MAIDEN NAME Frances Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		217-12-8581	Records-	US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

write the cause of death clearly and legibly. Print age is especially important. Physician please write

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac hypertrophy — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO with congestive failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio sclerotic heart disease 2 yrs.

DUE TO Also had diabetes mellitus - 5 yrs.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	None	None

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 1, 1949 *to* Aug. 3, 1949, *that I last saw the deceased alive on* Aug. 3, 1949, *and that death occurred at* 3:25A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert V. Jaffin M.D.	US Marine Hospital, Balto, Md.	8/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 6/49	Mt Calvary Cem	G.G. County Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 5 1949	Huntington Williams, M.D.	Mrs L.A. Elliott Dampman	1129 N. Carrove

VS 150

61

G76997 CERTIFICATE CORRECTED 8-8-49 x ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G76997 Registered No.

1. NAME OF DECEASED (Type or Print) Amelia Louise Payne

2. DATE OF DEATH August 4 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Thayer 1

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Garrett
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Garrett Co.
D. STREET ADDRESS (If rural, give location) 29 Pembroke St

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH 4-26-[illegible] | 9. AGE (In years last birthday) 67 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Holland | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Hageman

14. MOTHER'S MAIDEN NAME Hageman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningitis, purulent — INTERVAL BETWEEN ONSET AND DEATH: 12-15 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Neurofebrinia, cervical cord — 1 yr

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive vascular dis. — Years

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION Excision of neurofebrina | 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/20/49 *to* 8/4/49, *that I last saw the deceased alive on* 8/4, 1949, *and that death occurred at* 1:35 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Robert M Paine M. D. | 23B. ADDRESS JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED 8-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/6/49 | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge | 24D. LOCATION (City, town, or county) (State) Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 5 1949 | REGISTRAR'S SIGNATURE Hunter Jon Williams, M.D. | 25. FUNERAL DIRECTOR Wilkins Co Inc | ADDRESS 1217 Druid Pk

VS 150

93D

Please write the cause of death clearly and legibly. Physician please write the correct age is especially important.

G76998 BALTIMORE CITY HEALTH DEPARTMENT G76998
CERTIFICATE OF DEATH
Registered No. 450

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Loretto Wellmore

2. DATE OF DEATH 8/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2928 St. Paul Street
C. Length of stay in Baltimore About 78 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2928 St. Paul Street 12-07

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH --- About
9. AGE (In years last birthday) 78
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Registered
10B. KIND OF BUSINESS OR INDUSTRY Nurse

11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Edward Harwood
14. MOTHER'S MAIDEN NAME Josephine Maher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Ella W. Clark ADDRESS 2928 St. Paul

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Senility — Unknown
DUE TO
(B) Chronic Arthritis (Deformans) — Unknown
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Arteriosclerosis — Unknown

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/13, 1927, *to* 8/3, 1949, *that I last saw the deceased alive on* 8/3/49, 19___, *and that death occurred at* 9 m., *from the causes and on the date stated above.*

23A. SIGNATURE Charles R. Goesbrought M. D.
23B. ADDRESS 2923 St Paul St
23C. DATE SIGNED 8/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/6/49
24C. NAME OF CEMETERY ~~or CREMATORY~~ New Cathedral
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 5 1949
REGISTRAR'S SIGNATURE Deputy for Williams, M.D.
25. FUNERAL DIRECTOR Wm. U. Meades and Son ADDRESS 805 N. Calvert St

59a

Please write the cause of death clearly and legibly. Physician please write exact age is especially important.

G76999 — X ✓ — G76999

BIRTH NO. G76999

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

57 ✓ Registered No.

1. NAME OF DECEASED (Type or Print): JAMES PITTS

2. DATE OF DEATH: Aug. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Philadelphia
D. STREET ADDRESS (If rural, give location): 2935 Wharton St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 5/17/93
9. AGE (In years last birthday): 56 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): electrician
10B. KIND OF BUSINESS OR INDUSTRY: Seafarer
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Pitts
14. MOTHER'S MAIDEN NAME: Anna Bradley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 184-07-8732
17. INFORMANT: Records- US Marine Hospital, Balto, Md. (ADDRESS)

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G77000

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

023 Registered No. G77000

1. NAME OF DECEASED (Type or Print) ELLEN (GRANT) LEGRANT

2. DATE OF DEATH August 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Balto. Gen. Hosp.

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 647 W. Lee Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	Colored	W		50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	S. C.	

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Elias L. Grant	804 Fremont Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute congestive heart failure

DUE TO

(B) Luetic aortitis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH? | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED August 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/6/49	Mt Auburn	Salt City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 6 - 1949	Tuntington Williams, M.D.	D. I. Brown & Son	108 W. Montgomery St

VS 151

30D

Please write the cause of death clearly and legibly. Correct age is especially important. Physician

077001 — BALTIMORE CITY HEALTH DEPARTMENT — 591 — 077001

CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Ruth Wright

2. DATE OF DEATH: 8/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.
c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 223 W. Henrietta St. 23-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married		40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed		Maryland	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		George Wright	2210 Henrietta St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) UREMIA
DUE TO
(B) CHRONIC NEPHRITIS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
LOBAR PNEUMONIA

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/19, 1949 to 8/2, 1949 that I last saw the deceased alive on 8/2, 1949 and that death occurred at 8:10 P.M., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Samuel P. Scalia M. D.	So. Baltimore Gen. Hosp	8/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
Burial	8/6/49	Mt Auburn Ct	Balto City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 6 - 1949	Huntington Williams, M.D.	L. L. Brown & Son	108 W. Montgomery St

VS 150

108

77002 GM. 130672

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77002

1. NAME OF DECEASED (Type or Print): Carl Panchison

2. DATE OF DEATH: Aug. 4- 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 9 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Essex
D. STREET ADDRESS (If rural, give location): 209 " A " Woodvale RD. Z 21

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 7- 1912
9. AGE (In years last birthday): 37 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): PA.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank
14. MOTHER'S MAIDEN NAME: Evelyn Yurkobsky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records B.C.H. ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH INK. Fill in the cause of death clearly and correct age is especially important. Physicians: please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Glioma of RT. Parietal Cortex
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 8- 2- 1949
19B. MAJOR FINDINGS OF OPERATION: Brain Tumor
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7- 29- , 1949, *to* 8- 4- , 1949 *that I last saw the deceased alive on* 8- 4- , 1949, *and that death occurred at* 9.25 PM, *from the causes and on the date stated above.*

23A. SIGNATURE: H. L. Rogers M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 8-4-1949.

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Removal for Scranton Pa.
24D. LOCATION (City, Town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: AUG 6- 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR: Fred W. Ozarowski
ADDRESS: 1930 Eastern Ave.

VS 150

54B

G77003 ✓ 2 G77003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

STATE NO.

1. NAME OF DECEASED (Type or Print): Mrs. Ludwika Polek

2. DATE OF DEATH: Aug. 5/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1902 E. Pratt St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): None

C. Length of stay in Baltimore: 47 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): —
D. STREET ADDRESS (If rural, give location): 1902 E. Pratt St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	?	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	—	Poland	U S

13. FATHER'S NAME: Joseph Rice

14. MOTHER'S MAIDEN NAME: Rose Zaeuch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	None	Joseph Polek	1902 E. Pratt St

MEDICAL CERTIFICATION

Please write the cause for death clearly and correct age in especially important. Physician please write the cause for death clearly and correct age in especially important.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — Interval between onset and death: several years

DUE TO

(B) T. B. Infection — Interval between onset and death: years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Myocarditis, Secondary anemia — Interval between onset and death: months

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from Feb, 1947 to Aug 5, 1949, that I last saw the deceased alive on July 31, 1949, and that death occurred at 4 a m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. F. Ries M. D.	24 S. Broadway	Aug 5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	Aug 8/49	Holy Rosary	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 6 - 1949	Huntington Williams, M.D.	Fred W. Ozazewski	13 B.

VS 150

G77004

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77004

1. NAME OF DECEASED (Type or Print): ARTHUR RANDOLPH ROBINSON

2. DATE OF DEATH: AUG 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: PROVIDENT HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PROVIDENT HOSPITAL
C. Length of stay in Baltimore: 62 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 323 N. CALHOUN 19-01

5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: AUG. 3, 1887
9. AGE (In years last birthday): 62
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): POSTAL CLERK
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTO. MD
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ANDREW ROBINSON
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS MARGARET E ROBINSON
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 8-5-49
DUE TO
(B) Hypertension — 3 mos
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 2, 1949, *to* Aug 5, 1949 *that I last saw the deceased alive on* Aug. 5, 1949 *and that death occurred at* 9:55 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: H C Welborne M. D.
23B. ADDRESS: 1131 Harlem ave.
23C. DATE SIGNED: aug. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): B
24B. DATE: aug. 8, 1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Pk.
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Holland Funeral Home 624 Druid Hill Ave
ADDRESS:

94a

VS 150

PLEASE WRITE LEGIBLY. Use ink. Do not use pencil. Be sure to write the cause of death clearly and fully. Do not abbreviate. Be sure correct age is especially important. Physician: please write

G77005 X ✓ 080.0 G77005

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) CAROLINE [illegible] JACKSON

2. DATE OF DEATH AUGUST 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SYDENHAM HOSPITAL

c. Length of stay in Baltimore [illegible] 16 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE (RURAL)
D. STREET ADDRESS (If rural, give location) 3606 TELMAR ROAD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	SINGLE	SEPT 5, 1932	16		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
STUDENT	SFU	BALTIMORE, MARYLAND	✓

13. FATHER'S NAME SAMUEL HENRY JACKSON

14. MOTHER'S MAIDEN NAME DOROTHY CHURN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		[illegible]LMRS S.A. JACKSON	3606 TELMAR RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) BULBAR POLIOMYELITIS
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JULY 22, 1949, *to* August 3, 1949, *that I last saw the deceased alive on* August 3, 1949, *and that death occurred at* 3.30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Latimer Y. Young M. D.	Sydenham Hospital	8/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Aug 6-49	Lorraine Park	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 6- 1949	Huntington Williams, M.D.	Ellsworth Comacos	5118 Harford Ave.

VS 150

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PLEASE WRITE LEGIBLY. State the cause of death clearly and briefly. Physician: please write the correct age is especially important.

G77006

JL- 16052

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77006

1. NAME OF DECEASED (Type or Print): Nathaniel Reid

2. DATE OF DEATH: 7-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 49 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 424 N. Bond St 6-05

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan. 17, 1876
9. AGE (In years last birthday): 73 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): West Indies
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Walter Reid
14. MOTHER'S MAIDEN NAME: Rebecca Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion

DUE TO

(B) Arte riosclerotic Cardio-vascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-4-30, 19__, *to* July 30, 1949, *that I last saw the deceased alive on* July 30, 19 49 *and that death occurred at* 10.30 pm *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Rogers M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 8-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 8-6-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): G. C. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. A. Jackson
ADDRESS: 916 Penna. Ave

Vs 150

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PLEASE WRITE IN INK. Fill in the cause of death clearly and correct age is especially important. Physician: please write the

G77007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77007

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES SEITZ

2. DATE OF DEATH: Aug. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 513 S. Bouldin Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (if rural, give location): 513 S. Bouldin Street 26-11

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar. 23, 1876
9. AGE (In years last birthday): 73 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Processor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Seitz
14. MOTHER'S MAIDEN NAME: Elizabeth Borax

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-05-4550
17. INFORMANT: Mrs. Bettie Seitz 513 S. Bouldin Street

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, with ink. Physician: please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia
DUE TO
(B) Enteritis - arteriosclerotic heart disease
DUE TO
(C) Enteritis - acute

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/29, 1949, *to* 8/4, 1949, *that I last saw the deceased alive on* 8/4, 1949, *and that death occurred at* 8:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles Flora M. D.
23B. ADDRESS: 3123 Eastern Ave
23C. DATE SIGNED: 8/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/8/49
24C. NAME OF CEMETERY OR CREMATORY: First Evangelical Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: AUG 6 - 1949
REGISTRAR'S SIGNATURE: Contractor Williams, Mgr
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC

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BALTIMORE - 13, MARYLAND

93D

G77008

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3 4

G77008

Registered No.

1. NAME OF DECEASED (Type or Print) AGNES KIRSCH WEST

2. DATE OF DEATH Aug. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3316 Cardenas Avenue

C. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3316 Cardenas Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Married	Apr. 6, 1873	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frederick Kirsch	Wilhelmina Meisner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		none	3316 Cardenas Ave 13 Samuel J. West -

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral sclerosis, Arteriosclerosis

DUE TO

(B) Senility

DUE TO

(C) Paget's disease of bone.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 25, 1949, *to* Aug 3, 1949 *that I last saw the deceased alive on* Aug 3, 1949, *and that death occurred at* 10:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J B Stevens M. D.	3400 Erdman Ave	8/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/6/49	Baltimore Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 6 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC

VS 150

BALTIMORE - 13, MARYLAND

155

Please write the cause of death clearly and correct age is especially important. Physician: please write the

677009

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 677009

1. NAME OF DECEASED (Type or Print) WILLIAM EUGENE ROBERTS

2. DATE OF DEATH Aug. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 439 E. 28th St.

c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 439 E. 28th St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	white	married	May 24, 1878	71 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired ship joiner	ship building	Baltimore, Maryland	

13. FATHER'S NAME: John Thomas Roberts

14. MOTHER'S MAIDEN NAME: -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
yes	Spanish American	

17. INFORMANT: Mr. William P. Roberts — ADDRESS: 2035 Park Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY with ink or indelible pencil. Do not use ditto marks. Be sure the cause of death clearly and correct age is especially important. Physicians: please write these items carefully.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Arteriosclerotic Heart Disease — 5 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 4, 1947, *to* Aug 5, 1949, *that I last saw the deceased alive on* July 9, 1949, *and that death occurred at* 3:15 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George Dawson M. D.	4808 Harford Rd.	8/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/8/49	Lorraine Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 6- 1949	Custis Tolson Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

93D

G770.10

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54

Registered No. G770.10

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alice E. Reese

2. DATE OF DEATH August 5, 1949

3. PLACE OF DEATH: Baltimore City, Maryland Bon Secours Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

5a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hosp.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

5c. Length of stay in Baltimore: life (Yrs. Mos. Days)

d. STREET ADDRESS (If rural, give location) 3313 Alto Rd 15-37

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	Sept. 9, 1872	76 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Teacher	School	Baltimore	

13. FATHER'S NAME: William Philip Reese

14. MOTHER'S MAIDEN NAME: Annie Elizabeth Craig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Mr. Harold D. Oliver	3120 Brighton St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Large Bowel Obstruction	2 wks
DUE TO		
ANTECEDENT CAUSES	(B) Carcinoma of Recto-Sigmoid	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
August 5, 1949	Large Bowel Distension; Ca of Recto-Sigmoid	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5 Pm, 1949, *to* 9 Am, 1949, *that I last saw the deceased alive on* Aug 5, 1949, *and that death occurred at* 9:10 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank A. Faraone M. D.	Bon Secours Hospital	Aug 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/8/49	Lorraine Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 6 - 1949	Curtis for Williams, M.D.	WM. J. TICKNER & SONS	Baltimore Md.

VS 150

46D

PLEASE WRITE PLAINLY with pencil or pen and ink. Physician: please write the cause of death clearly and legibly. Please report correct age in years. Items 1 to 17 must be completed. Items 18 to 24 are important. Physician is especially requested to complete them.

G77011

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5400

Registered No. G77011

1. NAME OF DECEASED (Type or Print): FRANK EUGENE McALLISTER

2. DATE OF DEATH: August 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

c. Length of stay in Baltimore: 65 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2332 Riggs Avenue 1600

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 13, 1884 | 9. AGE (In years last birthday): 65 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10B. KIND OF BUSINESS OR INDUSTRY: Ice business

11. BIRTHPLACE (State or foreign country): Maryland (Balto.)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: McAllister, William

14. MOTHER'S MAIDEN NAME: Coon, Barbara

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.

17. INFORMANT (Daughter): Roe, Mrs. Elsie O. ADDRESS: 2650 Harlem Ave.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Peptic Ulcer

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 1, 1949, *to* August 5, 1949, *that I last saw the deceased alive on* August 4, 1949, *and that death occurred at* 12:50 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ronald S. Seaton M. D. | 23B. ADDRESS: Church Home & Hosp | 23C. DATE SIGNED: August 5/1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 8/8/49 | 24C. NAME OF CEMETERY OR CREMATORY: Western Cem. | 24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 6 - 1949 | REGISTRAR'S SIGNATURE: [illegible] Thos. Williams, M.D. | 25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS | ADDRESS: Balto., Md.

VS 150

117a

G77012
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-90 Registered No. G77012

1. NAME OF DECEASED (Type or Print): Robert Keve
2. DATE OF DEATH: August 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 947 W. Fayette St.
C. Length of stay in Baltimore: 50 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 947 W. Fayette St. 18-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Widow	Dec. 11, 1886	62 yrs.	7	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Northumberland Co. VA.	U.S.A.

13. FATHER'S NAME: John Keve
14. MOTHER'S MAIDEN NAME: Ann White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			Mary Carter	947 W. Fayette St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Day
DUE TO
(B) Lobar Pneumonia — Several months
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 20, 1949, *to* August 3, 1949, *that I last saw the deceased alive on* July 30, 1949, *and that death occurred at* 9:35 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard H. Hunt M. D.	1631 W. Franklin	8-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-7-49	Woodlawn Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 6 1949	Deputy for Matthews, M.D.	Mrs. Katie R. Williams & Sons	322

VS 150

108

BIRTH NO. G77013

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51 Registered No. G77013

1. NAME OF DECEASED (Type or Print): Benton Gmasemore

2. DATE OF DEATH: 8-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Arnold
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westminister
D. STREET ADDRESS (If rural, give location): R.7.D. # 4

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: 1-9-1887 | 9. AGE (In years last birthday): 62 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George H Masemore

14. MOTHER'S MAIDEN NAME: Mary E Bull

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ✓

17. INFORMANT: Henry Masemore | ADDRESS: Westminster Md

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write in all necessary information. Be especially important. Physician: please write the cause of death clearly and legibly. Be especially important

G77014 BALTIMORE CITY HEALTH DEPARTMENT 561.0 G77014

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Henry Goodman

2. DATE OF DEATH 8/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital
C. Length of stay in Baltimore 55 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2252 Linden Ave 1-3-07

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 1866
9. AGE (In years last birthday) 83
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Louis Goodman
14. MOTHER'S MAIDEN NAME Yetta P.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Samuel Goodman ADDRESS 2252 Linden ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Strangulated Inguinal Hernia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/6, 1949, *to* 8/6, 1949 *that I last saw the deceased alive on* 8/6, 1949, *and that death occurred at* 2.39 p m., *from the causes and on the date stated above.*

23A. SIGNATURE Mark Miller MD M. D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 8/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 7, 1949
24C. NAME OF CEMETERY OR CREMATORY Southern ave Cemty
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Sol Levinson & Bros
ADDRESS 1126 W North ave

VS 150

122a

G77015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4343 Registered No. G77015

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MR. WILLIAM SIMONDS

2. DATE OF DEATH 8-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland UNION MEMORIAL HOSP

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

C. Length of stay in Baltimore LIFETIME Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2825 HAMPDEN AVE. 12 07

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH
9. AGE (In years last birthday) 63 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD WORK
10B. KIND OF BUSINESS OR INDUSTRY RAILROAD
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME MR RICHARD SIMONDS
14. MOTHER'S MAIDEN NAME LAURA ROBINSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) UNKNOWN (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT MRS EDNA HERMAN ADDRESS 330 W 36TH ST.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) BASAL PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH approx 5 days
DUE TO
(B) CARDIAC DECOMPENSATION
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-4-49, 1949 *to* 8-5, 1949, *that I last saw the deceased alive on* 8-5-49, 19___, *and that death occurred at* 7 40 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE John S. Green, Jr. M. D.
23B. ADDRESS Union Memorial Hosp.
23C. DATE SIGNED 8-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried
24B. DATE Aug 9-49
24C. NAME OF CEMETERY OR CREMATORY Lorraine Pk
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 7 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Grant H. Beck
ADDRESS 814 W 36 St

VS 150

95C

BIRTH NO. G77016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77016

1. NAME OF DECEASED (Type or Print): SARA K. HOFFMAN

2. DATE OF DEATH: 8-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2419 Brookfield Ave

C. Length of stay in Baltimore: 68 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-01
D. STREET ADDRESS (If rural, give location): 2419 Brookfield Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH
9. AGE (In years last birthday): 693 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Wife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Romania
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Mendel

14. MOTHER'S MAIDEN NAME: Cohen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Morris Dorf ADDRESS: 2419 Brookfield Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic heart disease	2 days
	DUE TO Arteriosclerosis, general	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4 Aug 1949 to 6 Aug 1949 *that I last saw the deceased alive on* 5 Aug 1949 *and that death occurred at* 6:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Louis L. Hamburger Jr. M. D.
23B. ADDRESS: 1207 Eutaw Pl
23C. DATE SIGNED: 6 Aug 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-7-49
24C. NAME OF CEMETERY OR CREMATORY: Har Sinai
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

937

correct age is especial important. Physician, please write

BIRTH NO. G77017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1960

Registered No. G77017

1. NAME OF DECEASED (Type or Print): Silberschlag, Gussie

2. DATE OF DEATH: 8-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp. of Baltimore, Inc.

C. Length of stay in Baltimore: 38 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 2027 No Pulaski St

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH:
9. AGE (In years last birthday): 67 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rodel
14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Dave Silberschlag ADDRESS: 739 Wash - Blvd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(a) Severe Diabetes mellitus
DUE TO
(b) Coronary Thrombosis
DUE TO
(c) (?) Pulmonary or cerebral embolus

ANTECEDENT CAUSES.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-2, 1949 *to* 8-5, 1949 *that I last saw the deceased alive on* 8-5, 1949 *and that death occurred at* 1:00 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Nathan Thal, M. D.
23B. ADDRESS: Sinai Hospital, Baltimore
23C. DATE SIGNED: 8-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-7-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

AUG 7 150

61

Please write in ink. Physician: please write the cause of death in the space provided. Be sure to state correct age if especially important.

BIRTH NO. G77018

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

60° G77018 Registered No.

1. NAME OF DECEASED (Type or Print): Charles Eisenfeld

2. DATE OF DEATH: 8/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 604 W. North Avenue 13-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed		70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Benjamin Eisenfeld ADDRESS: 604 W North

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) SEVERE TOXEMIA
DUE TO
(B) ACUTE PYELONEPHRITIS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/31 1949 *to* 8/5 1949, *that I last saw the deceased alive on* 8/5 1949, *and that death occurred at* 11:25 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Samuel P. Scalia M. D.
23B. ADDRESS: 1213 Light Street
23C. DATE SIGNED: 8/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-7-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Young Men
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 7 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

61

Correct age is especially important. Physician: please write clearly.

CERTIFICATE CORRECTED 8-12-49

G77019 BALTIMORE CITY HEALTH DEPARTMENT G77019

BIRTH NO. CERTIFICATE OF DEATH 177 Registered No.

1. NAME OF DECEASED (Type or Print) Christopher Christ E. Kiering — 2. DATE OF DEATH Aug. 4/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2914 Winchester St

C. Length of stay in Baltimore Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md — B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16 07

D. STREET ADDRESS (If rural, give location) 2914 Winchester St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M.	W.	Widower	Mch. 19. 1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Manager — 10B. KIND OF BUSINESS OR INDUSTRY Ambassador Theatre

11. BIRTHPLACE (State or foreign country) Balto. Md — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Christopher Kiering — 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.

17. INFORMANT John Kiering — ADDRESS 2914 Winchester St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis

DUE TO

ANTECEDENT CAUSES

(B) Carcinoma of Prostate 1 year

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 3, 1949 *to* Aug 4, 1949 *that I last saw the deceased alive on* Aug 3, 1949 *and that death occurred at* 3a. m., *from the causes and on the date stated above.*

23A. SIGNATURE Homer H. Todd M. D. — 23B. ADDRESS 2108 St Paul St — 23C. DATE SIGNED 8/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE Aug. 8/49 — 24C. NAME OF CEMETERY OR CREMATORY Lorraine Pk. — 24D. LOCATION (City, town, or county) (State) Woodlawn, Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 7 1949 — REGISTRAR'S SIGNATURE Hunterton Williams, M.D. — 25. FUNERAL DIRECTOR Harry H. Nitzel — ADDRESS 4101 Edmondson Ave

VS 150

51B

correct age is especially important. Physician, please write the

Le. Hurl G77020 ✓ 1 G77020

244 N. Milton St

BIRTH NO. 7-8

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 420

1. NAME OF DECEASED (Type or Print): BERNICE E. STEWART

2. DATE OF DEATH: Aug 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1617 Darley Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1617 Darley Ave 8-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	Single	June 9 1875	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): /

10B. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Stewart

14. MOTHER'S MAIDEN NAME: Evelyn Lucas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Fannie B. McEntee ADDRESS: 453 W 28th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C) Chronic Cholecystitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: one wk.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 1, 1949 to Aug 4, 1949 that I last saw the deceased alive on Aug. 3, 1949 and that death occurred at 10:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Kenneth Krulewitz M. D.

23B. ADDRESS: 244 N. Milton St.

23C. DATE SIGNED: 8/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Aug 8/49

24C. NAME OF CEMETERY OR CREMATORY: Baltimore

24D. LOCATION (City, town, or county) (State): E. North Ave Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Thurston E. Donovan ADDRESS: 3818 Pkland Ave

VS 150

94a

G77021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

G77021 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MICHAEL — HEIN.

2. DATE OF DEATH Aug. 4th: 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 31-N. Rossuth St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

c. Length of stay in Baltimore 54 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimae

D. STREET ADDRESS (If rural, give location) 31-N. Rossuth St. 20-07

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed.

8. DATE OF BIRTH Feb. 22-1867 | 9. AGE (In years last birthday) 82 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Labor. | 10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co

11. BIRTHPLACE (State or foreign country) Germany. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown.

14. MOTHER'S MAIDEN NAME Unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no. | (If yes, give war or dates of service) no.

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Walter F. Yienger. ADDRESS 31-N. Rossuth St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
18. I	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) HYPERTENSIVE CARDIO-VASCULAR DISEASE.	5 yrs.
	ANTECEDENT CAUSES	DUE TO (B) ARTERIOSCLEROSIS	10 yrs
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* MARCH 1, 1949, to August 4, 1949, *that I last saw the deceased alive on* August 4 1949, *and that death occurred at* 6.30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Norman R. Kleiman M. D. | 23B. ADDRESS 3803 Edmondson Ave | 23C. DATE SIGNED 8/6/49.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial. | 24B. DATE Aug. 8- 49. | 24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cem | 24D. LOCATION (City, town, or county) (State) Baltimore - Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 7 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Charles J. Schwab. | ADDRESS 3512 Frederick Ave.

VS 150

931

correct age is especially important. Physicians: please write the cause of death clearly.

BIRTH NO. G77022

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77022

1. NAME OF DECEASED (Type or Print) CHRISTINE LEE

2. DATE OF DEATH August 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1908 Aisquith Street 9-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	colored	Single	Mar 11 1920	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John Lee
14. MOTHER'S MAIDEN NAME Erma Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Erma Wilson ADDRESS 1908 Aisquith St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pulmonary tuberculosis	
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L Kruger M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED August 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-7-49	Laurel	Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 7 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR Rayner Sanders ADDRESS 1312 1412 E. Preston St

VS 151

correct age is especially important. Physician: please write the cause of death clearly and legibly.

BIRTH NO. G77023

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77023

1. NAME OF DECEASED (Type or Print): Sister Mary Sebastian

2. DATE OF DEATH: August 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: 22 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Frederick
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmitsburg
D. STREET ADDRESS (If rural, give location): St. Joseph's Central House

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct 16, 1880
9. AGE (In years last birthday): 68
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pharmacist
10B. KIND OF BUSINESS OR INDUSTRY: Hospital
11. BIRTHPLACE (State or foreign country): Sennaly, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Nicholas Sebastian
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Ball

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sister Martina ADDRESS: Emmitsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary thrombosis, acute
DUE TO
(B) Generalized arteriosclerosis
DUE TO
(C) Diabetes Mellitus — 4-5 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/14, 1949 *to* 8/6, 1949, *that I last saw the deceased alive on* 8/5, 1949, *and that death occurred at* 3 A. m. *from the causes and on the date stated above.*

23A. SIGNATURE: Robert J. Lesicka M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 8/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 8/8/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: AUG 7 1949
REGISTRAR'S SIGNATURE: Emmitsburg, Maryland
25. FUNERAL DIRECTOR: M. Fahey & Sons ADDRESS: 1827 W. North Ave.

VS 150

61

G77024 E 885.0 ✓ G77024

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C.H. 31249

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Frank D. Snyder N-966.0

2. DATE OF DEATH: Aug 4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1513 Asquith St. 9-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	Aug-26/15	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore-Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward F. Snyder
14. MOTHER'S MAIDEN NAME: Geraldine Faulkoki

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Edward F. Snyder — ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Failure and — INTERVAL BETWEEN ONSET AND DEATH: about 1 month
DUE TO
Pulmonary Edema
(B)
DUE TO Lead poisoning (occ)
(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-3, 1949 to 8-4, 1949 *that I last saw the deceased alive on* 8-4, 1949, *and that death occurred at* 5:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Judith B. Landau M. D.	Sinai Hospital Balto	8-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 8/49	Loudon Park	Balto-Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 7 1949	Huntington Williams, M.D.	F. R. Wipfler's Son	1300 Eutaw Pl 17

VS 150

78 D

correct age is especially important. Physician: please write clearly.

G77025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77025

BIRTH NO.

1. NAME OF DECEASED. (Type or Print) GEORGE WILLIAM BOETTINGER

2. DATE OF DEATH 8/4/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 626 Melville avenue

c. Length of stay in Baltimore Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write NO. RAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 626 Melville avenue 9-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	Married	10/31, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meteorological Instrument Maker
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md,
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George W. Boettinger
14. MOTHER'S MAIDEN NAME Mary Louisa Claus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-03-2959
17. INFORMANT 626 Melville ave. ADDRESS Mrs. Marie Hartman Boettinger

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 mos

DUE TO

(B) Nephrosclerosis — 15 yrs

DUE TO

(C) Hypotension and cerebral hemorrhage — Known by me since 1942

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 5 1942 *to* Aug 4, 1949 *that I last saw the deceased alive on* Aug 4, 1949, *and that death occurred at* 10.30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE John A. Luetscher M. D. — 23B. ADDRESS 12 E Eager St, Baltimore — 23C. DATE SIGNED Aug 5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/8/49	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 7 1949 VS 150

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Chas. J. Evans & Son Inc. — ADDRESS: 118 West Mount Royal ave.

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Correct age is especially important. Physician: please write in full.

BIRTH NO. G77026

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77026

1. NAME OF DECEASED (Type or Print): JOHN AIREY

2. DATE OF DEATH: August 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. Gen. Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN: Baltimore, (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 2752 Baker Street 15-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	March 9 1893	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cambridge, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Franklin Airey

14. MOTHER'S MAIDEN NAME: Sophia Kimmey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Milton Krout. ADDRESS: 2752 Baker St. Balto.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Wilson J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [X]
ASSISTANT MEDICAL EXAMINER [ ]
MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: August 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 8, 1949	Cedar Hill Cemetery	A. A. County, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: AUG 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: FLYNN & FLEMING ADDRESS: 1426 Light St.

VS 151

94a

Please write the cause of death clearly and legibly. Physician: please write the correct age in years. If under 1 year, give age in months, days, hours or minutes. Information as to age is especially important.

G77027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33

Registered No. G77027

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rose Repson Huart

2. DATE OF DEATH 8/5/49 1:20 a.m.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2814 Guilford Ave

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 12-3
D. STREET ADDRESS (If rural, give location) 2814 Guilford Ave

5. SEX	6. COLOR OR RACE	7. ~~SINGLE, MARRIED~~, WIDOWED, ~~DIVORCED (Specify)~~	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	11/11/1867	81	8 24	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Balto. Md.	

13. FATHER'S NAME Peter Repson

14. MOTHER'S MAIDEN NAME Minnie Quartman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			D. M. Steffey	N. Y.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebral Hemorrhage.	4 days
	DUE TO (B) Hypertension	years.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Chronic Epilepsy	years.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None.	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	no	no

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
no m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 2, 1949, *to* Aug. 5, 1949 *that I last saw the deceased alive on* Aug. 5, 1949 *and that death occurred at* 1:20 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank N. Ogden M. D.	2701 N. Calvert St.	Aug. 5, 49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	8/8/49	London Park	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 8 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 150

Collect age is especial important. Physician please write

83a

G77028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. G77028 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jesse M Boland

2. DATE OF DEATH Aug. 4. 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4017 Falls Road
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4017 Falls Road 13-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	March 2, 1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plumber	Retired Plumbing	Baltimore Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas B Boland	Jessie Murray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Spanish War	205-03-6698	Edmond B Boland	2422 N Rogers Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Chronic arteriosclerotic heart disease — I 10 yrs

DUE TO (C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia, L.L.L.; healing — 2 wks

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 June, 1949, to 4 Aug, 1949, that I last saw the deceased alive on 4 Aug, 1949, and that death occurred at 11:58 m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Fred B Agg Jr M. D.	2813 St Paul	6 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/8/49	Mahoney	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 8 1949	Huntington Williams, M.D.	Wilhelm & Son Inc	1219 St Paul St

VS 150

937

Cause of Age is especial importance. Physician, please give

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E977 G77029 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joel Rebeck — 2. DATE OF DEATH Aug 7 1949 — 4:45 PM

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto Gen Hosp.
C. Length of stay in Baltimore 3 Mos.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-9
D. STREET ADDRESS (If rural, give location) 3925 Norfolk Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	1	32		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Russia	

13. FATHER'S NAME Isaac

14. MOTHER'S MAIDEN NAME Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			S. Rebeck	3925 Norfolk Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Exsanguination due to

DUE TO

(B) Laceration of Neck Vessels

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3925 Norfolk Ave

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 7 1949 2:30 p.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Cut his throat with a razor blade

22. *I certify that I took charge of the remains described above, held an* Aug Ed Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE William L Kelbeck M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED Aug 7 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Interment	8-8-49	Beth Tfiloh	Dallo Md

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Rewsdc — ADDRESS 2100 Eutaw Pl

VS 151

167

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G77030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57 G77030 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Klugh

2. DATE OF DEATH August 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pa. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lansdowne
D. STREET ADDRESS (If rural, give location) 429 Hummel Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	3-20-75	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Banker		Pa.	

13. FATHER'S NAME Henry Klugh

14. MOTHER'S MAIDEN NAME Elizabeth Riseley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gangrene of Intestine
DUE TO
(B) Mesenteric Thrombosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8/5/49	Mesenteric Thrombosis	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-30, 1949 *to* 8-7, 1949 *that I last saw the deceased alive on* 8-7, 1949 *and that death occurred at* 4:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward P Johns M. D.	JOHNS HOPKINS HOSPITAL	8/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	8-8-49		Harrisburg Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
1949	Huntington Williams, M.D.	John A. Moran	3000 Balto St.

CORRECT AGE IN ESPECIAL, IMPORTANT, LEGAL, ETC.

VS 150

123

G77031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G77031

1. NAME OF DECEASED (Type or Print) GEORGE G. CODER

2. DATE OF DEATH 8-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTO GENERAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 27-5
D. STREET ADDRESS (If rural, give location) 3813 BIRCHVIEW AVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	NOV. 8 1913	35		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MAPLETON PENNA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME late ELMIRA SWANGER

14. MOTHER'S MAIDEN NAME late ANN K. GREENLAND

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 169-07-5192

17. INFORMANT — ADDRESS
MRS ELMIRA CODER - 3813 BIRCHVIEW AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Adrenal hemorrhage (right)
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. hypocardial infarction, old

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-5-19 49 *to* 8-6-19 49, *that I last saw the deceased alive on* 8-6-19 49 *and that death occurred at* 8 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE Harry D Yaggupian M. D.

23B. ADDRESS So. Balto. Gen. Hosp.

23C. DATE SIGNED 8-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	AUG. 9 '49	FAIRVIEW CEM.	ALTOONA, PA

DATE RECEIVED BY REGISTRAR AUG 9 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS
HARRY H WITKE - 4101 EDMONDSON

VS 150

H.7167 A2 UJ, AN 65B AVE

G770.32 351 ✓ 4b ✓ G770.32

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Beverly Barrick

2. DATE OF DEATH: August 6, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

c. Length of stay in Baltimore: 6 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-3
d. STREET ADDRESS (If rural, give location): 108 Scott Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	June 1, 1943	6 years				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child	child	Maryland	U.S.A. ✓

13. FATHER'S NAME: Calvin Barrick

14. MOTHER'S MAIDEN NAME: Doris Engles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	none	Mother	108 Scott street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, Aspiration — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

(B) Cerebral Palsy — 6 years

DUE TO

(C) Malnutrition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	none

22. *I hereby certify that I attended the deceased from* July 31, 1949, *to* August 6, 1949, *that I last saw the deceased alive on* August 6, 1949, *and that death occurred at* 4:20 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles T. Henderson M. D.	University Hospital	August 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	AUG. 9 1949	MT. OLIVET	BALTO. MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 8 1949	Huntington Williams, M.D.	Harry A. Wetzler - 411 Edmondson Ave	

VS 150

831

G770333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17 Registered No. G770333

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PAULINE V. HINKEL

2. DATE OF DEATH AUG. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 108 S. CULVER ST

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 20-7
D. STREET ADDRESS (If rural, give location) 108 S. CULVER ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	MARRIED	JAN. 13 1893	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) PENNA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME CLIFTON SAUERHAMMER

14. MOTHER'S MAIDEN NAME SUSAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS
Mr HARRY HINKEL - 108 S. CULVER ST

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) CARCINOMATA OF THE BREAST	8 YRS
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1941.	CARCINOMATA OF RIGHT BREAST.	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO	-	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19 41 *to* Aug, 4, , 19 49, *that I last saw the deceased alive on* Aug, 4, 1949 *and that death occurred at* 5: 00 PM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. Lloyd Adkinson M. D.	CATONSVILLE MARYLAND	Aug/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	AUG. 8 1949	MT. CARMEL	LITTLESTOWN, PA.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
AUG 8 1949	Contington Williams, M.D.	Harry N. Withee - 4101 Edmondson Ave

VS 150

50

70.34 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 974.6 G770.34 Registered No.

1. NAME OF DECEASED (Type or Print) Edwin Goetz N-991. 2. DATE OF DEATH 8-6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 122 E. Pratt St.
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY ALLEGHANY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) FROSTBURG
D. STREET ADDRESS (If rural, give location) 280 E. MAIN St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	MARRIED		54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MT. SAVAGE, MD.	U.S.

13. FATHER'S NAME EDWIN GOETZ

14. MOTHER'S MAIDEN NAME ALICE PORTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT, ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation

DUE TO

(B) Hanging

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	hotel	Newfoundland Hotel, Charles & Pratt Sts.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 6, 1949 ? m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Hanged self by rope from door frame

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
M.D.		8-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-10-1949	St. Georges	Mt. Savage MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 8 1949	Huntington Williams, M.D.	H.W. Jenkins & Sons Co.	4905 York Rd

VS 151

164a

77035 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4th 1 Registered No. 77035

1. NAME OF DECEASED (Type or Print): Louis C. Houston

2. DATE OF DEATH: 6 Aug. 1949.

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caton & Wilkens ave — St. Agnes Hospital (DOA)

c. Length of stay in Baltimore: 35 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arbutus

D. STREET ADDRESS (If rural, give location): 1326 Birch ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Feb 21-1891	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Superintendent	Construction Wk.	Va.	U.S.

13. FATHER'S NAME: Benjamin Houston

14. MOTHER'S MAIDEN NAME: Della Gunther

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Mamie S. Houston	1326 Birch ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy / Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ / ASSISTANT MEDICAL EXAMINER ☐ / MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
Wm. H. Kammer, M.D.		7 Aug. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 9-1949	Lorraine Park Cem	Woodlawn Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Aug 9 1949	Huntington Williams, M.D.	Geo L. Boyer Jr	1512 Hollins St

VS 151

94a

~~70.36~~ BALTIMORE CITY HEALTH DEPARTMENT G770.36

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Carrie A. Smith

2. DATE OF DEATH Aug. 6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1190 Wash. Blvd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

c. Length of stay in Baltimore 60- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-2
D. STREET ADDRESS (If rural, give location) 1180 Washington Blvd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	White	Married	Aug 10-1888	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Baltimore Md	

13. FATHER'S NAME George Keller

14. MOTHER'S MAIDEN NAME Elizabeth Hammell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. George H. Smith	1180 Wash. Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Obesity

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJUBY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-4, 1949 *to* 8-6, 1949, *that I last saw the deceased alive on* 8-6, 1949, *and that death occurred at* 4:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John P. Unluch Jr. M. D.	1227 Wash. Blvd	8-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 10-49	Western Cem.	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 8 1949		Geo. L. Berger Jr	1512 Hollins St

VS 150

94a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

60

BIRTH NO. 270.47

Registered No. 6270.47

1. NAME OF DECEASED (Type or Print): GEORGE FREDERICK SCOTT

2. DATE OF DEATH: August 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1915 Cecil Avenue
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1915 Cecil Avenue 9-8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	Dec. 23, 1868	80				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Signal DepT 8- Ret.	Penna R.R. Co.	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Scott	Mary Agnes Toomey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (Name and ADDRESS)
No		none	1915 Cecil Ave Mrs. Annei M. Scott

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO
(B) Carcinoma of T. Antrum — Unknown
DUE TO
(C) Arterioscleratic Cardio-Vascular Disease — Unknown
DUE TO
(D) Generalized Arteriosclerosis — Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 1, 1949 *to* Aug 4, 1949 *that I last saw the deceased alive on* Aug 3, 1949 *and that death occurred at* 4:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. Brulenitz, M.D. M. D.	244 N Hilton ST.	8/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/8/49	Parkwood Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 8 50 1949	Thurlington Williams, M.D.	HENRY SANDER & SONS, INC. BALTIMORE - 13, MARYLAND

55D

70:38

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C.49-10934

CERTIFICATE OF DEATH

393 G770:38 Registered No.

1. NAME OF DECEASED (Type or Print): Margaret Nettie Bryan

2. DATE OF DEATH: 8-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore during hospitalization: Yrs. none Mos. 24 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson, Md.
D. STREET ADDRESS (If rural, give location): 201 Maryland Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	single	5-24-48	1	2 / 13	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Maryland	USA

13. FATHER'S NAME: Edmund Bryan, Jr.

14. MOTHER'S MAIDEN NAME: Marian Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	Mrs. Marian Bryan	201 Maryland Ave Towson, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Hemolytic Anemia — (INTERVAL BETWEEN ONSET AND DEATH) 21 days
DUE TO
(B) Infection — 9 wks
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-30-49	Mastoidectomy at Mercy Hospital	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	no	no

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
no m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	no

22. I hereby certify that I attended the deceased from 7-14, 1949, to 8-7, 1949, that I last saw the deceased alive on 8-7, 1949, and that death occurred at 7:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald B. Bond M. D.	Union Memorial Hospital	8-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	8/10/49	Parkwood	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 8 1949	Huntington Williams, M.D.	Lassahn Funeral Home	7401 Belair R

VS 150

correct age is especially important. Typewriter

898

770.39

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 4 ✓

770.39

Registered No.

1. NAME OF DECEASED (Type or Print) **Nellie (Ella) Corcoran**

2. DATE OF DEATH **Aug.5/49**

3. PLACE OF DEATH: **Baltimore City, Maryland** 1807 Eutaw Place

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Elmhurst Nursing Home**

c. Length of stay in Baltimore **Life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **2022 E.Hoffman St.** B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Balto. Md.**

D. STREET ADDRESS (If rural, give location) **2022 E.Hoffman St.** 8-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	July 4,1873	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
---	---	Balto. Md.	

13. FATHER'S NAME **Martin Corcoran**

14. MOTHER'S MAIDEN NAME **Katherine --**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr.Leo. Nelson,	1802 E.Fayette St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Hypertensive C V D** DUE TO

(B) DUE TO

(C) **Left sided hemiplegia**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 1, 1949, *to* Aug 5, 1949 *that I last saw the deceased alive on* 8/5, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hamilton J Hendrix M. D.	2331 Eastern Ave	8/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug.9/49	New Cathedral Cem	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 8 1949	Huntington Williams, M.D.	Philip Herwig Sons	2024 Orleans

VS 150

93D

77040

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

77040

Registered No.

1. NAME OF DECEASED (Type or Print) George W. Kelch

2. DATE OF DEATH Aug. 6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2213 Canary Court

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township.) Balto. 1-5

D. STREET ADDRESS (If rural, give location) 2213 Canary Court

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Widower	May 22-1885	64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator

10B. KIND OF BUSINESS OR INDUSTRY Packing House

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Kelch

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-10-5957

17. INFORMANT Edna Foos ADDRESS 2221 Canary Court

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Acute Cardiac Dilatation	1 day
DUE TO (B)	Cardiac Asthma	2 yrs.
DUE TO (C)	Chronic Myocarditis	5 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug - 5, 1941, *to* Aug 6, 1949 *that I last saw the deceased alive on* Aug 6, 1949 *and that death occurred at* 8:30 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE John V. Bayuk M. D.

23B. ADDRESS 1802 Eastern Ave

23C. DATE SIGNED 8-6-49.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Aug. 10-49

24C. NAME OF CEMETERY OR CREMATORY Schwartz's Fam.

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 8 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John L. Miller

ADDRESS 2334 Jefferson St.

937

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 770-A

Registered No. G77041

1. NAME OF DECEASED (Type or Print) Thomas H Sears — 2. DATE OF DEATH Aug. 6/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto City Hosp

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md — B. COUNTY Balto

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Essex

D. STREET ADDRESS (If rural, give location) 423 S. Marlyn Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	widower	May. 13/73	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Construction	U S A	

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		unknown	Samuel E Sears

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull c

DUE TO

(B) intra cranial hemorrhage

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, store, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	public	In front of 423 S.Marlyn Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21F. HOW DID INJURY OCCUR?
August 6, 1949 Approx. 4:20 p. m.		Ped. struck by auto.

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil L Royer M.D.		7 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/10/49	Oak Lawn	Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
AUG 8 1949	Huntington Williams, M.D.	J. J. Burzynski	1407 Eastern Ave

VS 151

170C

G770:2

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G770:2

1. NAME OF DECEASED (Type or Print) **FRANCIS BOONE**

2. DATE OF DEATH **8-4-49.**

3. PLACE OF DEATH
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **626 Greenwillow Street**

c. Length of stay in Baltimore **I3 years** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland.** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore I, 17-2**

D. STREET ADDRESS (If rural, give location) **626 Greenwillow Street**

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	Colored	Married	4-I2-I920	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Domestic	Private	North Carolina	U.S.A.

13. FATHER'S NAME **John Hobbs**

14. MOTHER'S MAIDEN NAME **Martha ?**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Jas. Boone	626 Greenwillow Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Broncho Pneumonia	7/1/49
DUE TO (B)	Pleurisy of a	4/1/49
DUE TO (C)	Tuberculous origin due to exposure.	4/1/49.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-1 19 49 *to* 8-4 19 49, *that I last saw the deceased alive on* 8-4 19 49 *and that death occurred at* 6:3[illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jas. R. Blake M. D.	1603-N. Carolane	8-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-8-49	Mt. Auburn Cemetery	Baltimore 30,

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 8 1949	Huntington Williams, M.D.	Wm. A. Jackson	916 Penna. Ave.

VS 150

13B

G77043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77043

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Norton, Annie

2. DATE OF DEATH Aug. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md.
D. STREET ADDRESS (If rural, give location) 136 W. Fort Ave 23-1

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W. Dowed

8. DATE OF BIRTH Aug 15 1878 | 9. AGE (In years last birthday) 70 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Graham

14. MOTHER'S MAIDEN NAME Emma Phillips

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) — | (If yes, give war or dates of service) — | 16. SOCIAL SECURITY NO. ✓

17. INFORMANT Mrs Florence Beckhardt ADDRESS 136 W Fort Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
DUE TO
(B) Coronary thrombosis ?
DUE TO
(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-5, 1949, *to* 8-6, 1949, *that I last saw the deceased alive on* 8-6, 1949, *and that death occurred at* 12:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE Geo Bakeman M. D. | 23B. ADDRESS Franklin Sq Hosp | 23C. DATE SIGNED 8-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/9/49 | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park | 24D. LOCATION (City, town, or county) (State) 3801 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR AUG 8 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR John J. Cowan & Son | ADDRESS Gilmor & Baltimore

VS 150

94a

7044

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-0 .1 G770:4 Registered No.

1. NAME OF DECEASED (Type or Print) JOHN EDWARD HUBER

2. DATE OF DEATH 8/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. JOSEPH'S HOSP

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 23-3
D. STREET ADDRESS (If rural, give location) 1833 S. Charles St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	6-18-1906	43				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bartender		Baltimore Md	

13. FATHER'S NAME John E. Huber.

14. MOTHER'S MAIDEN NAME Laura L. Hoobler.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No.		Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion — Interval between onset and death: 1 day
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute pulmonary edema

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/6, 1949, *to* 8/6, 1949 *that I last saw the deceased alive on* 8/6, 1949, *and that death occurred at* 1135 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thaddeus Swirieski M. D.	St. Joseph's Hosp.	8/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B.	8-10-49	Glen Haven	Glen Burnie

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 8 1949	Huntington Williams, M.D.	James L. McCauley	730 E Fort Ave

VS 150

94a

G770-5 ✓ x G770-5

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

776 Registered No.

1. NAME OF DECEASED (Type or Print) Baby Girl Giles

2. DATE OF DEATH 8/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore Genl Hospital

C. Length of stay in Baltimore: Yrs. — Mos. — Days 3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY A.A.Co.
C. CITY OR TOWN ~~City~~ Linthicum Hgts
D. STREET ADDRESS (If rural, give location) Nursery Road.

5. SEX F.

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 8/4/49

9. AGE (In years last birthday) | If Under 1 Year: Months | Days 2 | If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Balt.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME David L. Giles.

14. MOTHER'S MAIDEN NAME Dolores Baer.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/4/49, 19__, *to* 8/6/49, 19__, *that I last saw the deceased alive on* 8/6/49, 19__, *and that death occurred at* 6:29 P m., *from the causes and on the date stated above.*

23A. SIGNATURE D. Phenna M. D.

23B. ADDRESS So. Balt. Gen'l. Hosp.

23C. DATE SIGNED 8/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify) B

24B. DATE 8-8-49

24C. NAME OF CEMETERY OR CREMATORY Glen Haven

24D. LOCATION (City, town, or county) (State) Glen Burnie

DATE RECEIVED BY LOCAL REGISTRAR AUG 8 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR James L. McCully

ADDRESS 130 E. Fort Ave. 159

VS 150

G7046

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

44 6. G770:6 Registered No.

1. NAME OF DECEASED (Type or Print): Emma M. Fahey

2. DATE OF DEATH: 8/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 38 E. Hill St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 38 E Hill St B. COUNTY Dato Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) 38 E Hill St 22-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	Not Known	abt 75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY: own Home

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY: U. S.

13. FATHER'S NAME: Henry Kalea

14. MOTHER'S MAIDEN NAME: Caroline Vandenberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Emma Rammel ADDRESS: 38 E Hill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho Pneumonia — Interval between onset and death: 36 Hrs

DUE TO (B) arteria Sclerosis + Hypertension — 1 yr

DUE TO (C) Mitral Regurgitation Rheumatic — 1 mo

DUE TO Chronic Interstitial Nephritis — 1 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral Hemorrhage — 1 yr 2 mo

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 6 1949, to Aug 6 1949, *that I last saw the deceased alive on* Aug 5 1949, *and that death occurred at* 10:10 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: L. L. A. Stearns M. D.

23B. ADDRESS: 2878 Harford Av

23C. DATE SIGNED: 8-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 8/9/49

24C. NAME OF CEMETERY OR CREMATORY: Catherine

24D. LOCATION (City, town, or county) (State): Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: AUG 8 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: J. J. Fahey Sons ADDRESS: 13 S Eutaw

VS 150

131a

G770-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

010 Registered No. G770-47

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Melvin Wisniewski

2. DATE OF DEATH Aug. 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Dale 6

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-5

D. STREET ADDRESS (If rural, give location) 231 S. Collington Ave

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 3-23-23

9. AGE (In years last birthday) 26 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Wisniewski

14. MOTHER'S MAIDEN NAME Sophia Lokicka

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningitis

DUE TO

(B) Tuberculosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/3, 1949 *to* 8/6, 1949 *that I last saw the deceased alive on* 8/6, 1949, *and that death occurred at* 1/2 *m., from the causes and on the date stated above.*

23A. SIGNATURE Philip D. Hagley M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Aug. 9/49

24C. NAME OF CEMETERY OR CREMATORY Holy Rosary

24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR AUG 8 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Fred W Ozarowski ADDRESS 1900 Edgewood Ave 14

FORM VS 150

G7708 ✓X 1953 G7708

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

DEATH NO. 77 Registered No.

1. NAME OF DECEASED (Type or Print) JOHN H. CAIN

2. DATE OF DEATH August 7, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.

b. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pasadena P. O.
D. STREET ADDRESS (If rural, give location) Powhatton Beach

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	Dece. 23, 1899	49 50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cook	Wolf's Tavern	Oswego, New York	U.S. A.

13. FATHER'S NAME: John N. Cain, born, Oswego, New York

14. MOTHER'S MAIDEN NAME: Cora E. Bartholomew -- born, Oswego, N.Y.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Undetermined (only skeleton remains)

DUE TO (Found in rear of 5410 Pennington Avenue)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑.*

23A. SIGNATURE		23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
Georg G. Merrill	M.D.		8/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-10-49	Glen Haven	Glen Burnie

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 8 1949	Huntington Williams, M.D.	J. W. Singleton	Glen Burnie

VS 151

200B

G77049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77049 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) G. Carroll O. Lockard

2. DATE OF DEATH 8-7-49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-2
D. STREET ADDRESS (If rural, give location) 2925 N. Charles Street

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Feb 22 1882
9. AGE (In years last birthday) 67 If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician
10B. KIND OF BUSINESS OR INDUSTRY Medicine
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James G. Lockard
14. MOTHER'S MAIDEN NAME Marian J. Riddle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Louise W. Lockard ADDRESS 2925 N. Charles St

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intra Cerebral Hemorrhage — 12 hrs
DUE TO
(B) Monocytic Leukemia — 3 mos
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 8-3-49
19B. MAJOR FINDINGS OF OPERATION Carcinoma of Rectum
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* 8-7, 1949, *and that death occurred at* 4:13 A m., *from the causes and on the date stated above.*

23A. SIGNATURE William J. Halloway M. D.
23B. ADDRESS Redwood & Greene Sts
23C. DATE SIGNED 8-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8-9-49
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge
24D. LOCATION (City, town, or county) (State) Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 8 1949
REGISTRAR'S SIGNATURE Thurlington for Williams, M.D.
25. FUNERAL DIRECTOR John O. Mitchell & Sons, Inc. ADDRESS 1900 Eutaw Place
Mrs Mitchell 467

VS 150

G77050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

Registered No. G77050

STATE NO.

1. NAME OF DECEASED (Type or Print) William Walter Proctor.

2. DATE OF DEATH 8/6/49.

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1931 E Jefferson St.
c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-4
D. STREET ADDRESS (If rural, give location) 1931 E Jefferson St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year, last birthday)	Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C.	Married	Jan 16, 1894	55	8	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer.	—	Baltimore, Md.	U.S.A.

13. FATHER'S NAME Daniel Proctor.

14. MOTHER'S MAIDEN NAME Fannie Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes (If yes, give war or dates of service) WWI

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Ria Davis ADDRESS 1208 E Lexington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Metastasis, CA Bowel (Possible cancer metastasis to brain) — INTERVAL BETWEEN ONSET AND DEATH 6 mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) —
DUE TO
(C) —

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify, that I attended the deceased from* 7/24, 1949 *to* 8/6, 1949 *that I last saw the deceased alive on* 8/6, 1949 *and that death occurred at* 7 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Clarence L Hunt M. D.	1431 Mendell Ave	8/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug-10-49	U.S. Balto National	Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 8 1949	Huntington Williams, M.D.	Rayner Sanders	1412 E Preston St

VS 150

46E

G77051 Theiss G77051

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

STATE NO. B.C. 48-16662 Registered No.

1. NAME OF DECEASED (Type or Print) Eileen Theiss — Code should read 756.4

2. DATE OF DEATH 8/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Sinai Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3313 E. Baltimore St 26-10

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 8-9-48
9. AGE (In years last birthday) — If Under 1 Year: Months 11; Days; If Under 24 Hours: Hours; Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Theiss
14. MOTHER'S MAIDEN NAME Ann Diller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Ann Diller ADDRESS 3313 E. Balt. St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis of liver.
DUE TO
ANTECEDENT CAUSES
(B) Cong. Biliary Atresia
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/3/49, 19__, *to* 8/7/49, 19__, *that I last saw the deceased alive on* 8/7/49 19__, *and that death occurred at* 11:50A m., *from the causes and on the date stated above.*

23A. SIGNATURE Lee N. Kaston, M.D.
23B. ADDRESS 6 Sinai
23C. DATE SIGNED 8/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8-9-49
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery
24D. LOCATION (City, town, or county) Pikesville (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 8 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Chas. Dill
ADDRESS 1521 E. Fort Ave.

VS 150

1579

G77052

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77052

1. NAME OF DECEASED (Type or Print) M. Cornelia Hildreth

2. DATE OF DEATH Aug. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2017 E. 32nd. Street

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2017 E. 32 nd. Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Jan. 21, 1890	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Teacher	Garrison Jr. High	Baltimore, Md.	USA

13. FATHER'S NAME: William C. Burns

14. MOTHER'S MAIDEN NAME: Carolyn Deitrich

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO	NO	NO

17. INFORMANT: Clarence Hildreth ADDRESS: 2017 E.32nd. St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: appox. one hr.

DUE TO

(B) Hypertensive Cardio-Vascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August 1, 1949, *to* August 6, 1949, *that I last saw the deceased alive on* August 3 1949, *and that death occurred at* 10:15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Crawford N. Kirkpatrick, Jr. M. D.	6 E. Eager St, Baltimore, Md.	Aug. 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 9, 1949	Loudon Park	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 8 1949	Huntington Williams, M.D.	J.T. Stansbury	2700 Edmondson Ave.

VS 150

937

IFICATE CORRECTED 8-8-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77053

G77053
BIRTH NO.

1. NAME OF DECEASED (Type or Print) IKA Ruthraoff

2. DATE OF DEATH Aug 7, 1949.

3. PLACE OF DEATH: a. Baltimore City, Maryland Balt. Md.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland Gen. Hosp.

c. Length of stay in Baltimore 64 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Balt.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-1

d. STREET ADDRESS (If rural, give location) 1115 Greenmount Ave

5. SEX male | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH July 13 1886 | 9. AGE (In years last birthday) 63 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) watchman

10B. KIND OF BUSINESS OR INDUSTRY UNIVERSAL CAR LOADING CO.

11. BIRTHPLACE (State or foreign country) Md Williamsport

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME AUGUSTUS ROTHRAOFF

14. MOTHER'S MAIDEN NAME Lizzie Canby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO —

16. SOCIAL SECURITY NO. 216-07-4119

17. INFORMANT Mary J. Ruthraoff ADDRESS 1115 Greenmount Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Localized Peritonitis

DUE TO

(B) Malignant Gastric Ulcer

DUE TO

(C) Arteriosclerotic Heart Disease with Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH 2 weeks

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION July 21 1949 | 19B. MAJOR FINDINGS OF OPERATION Strangulated Hernia - Appendectomy | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/21 1949 to Aug 7, 1949 that I last saw the deceased alive on Aug 7, 1949 and that death occurred at 3 p.m., from the causes and on the date stated above.

23A. SIGNATURE R. G. Martin M. D. | 23B. ADDRESS Maryland Gen. Hosp. | 23C. DATE SIGNED 8-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8-10-1949 | 24C. NAME OF CEMETERY OR CREMATORY Williamsport Cemetery | 24D. LOCATION (City, town, or county) (State) Williamsport Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 8 1949 | REGISTRAR'S SIGNATURE Huntington Williams M.D. | 25. FUNERAL DIRECTOR Walter Conklin ADDRESS 924 E. Eager St.

VS 150

122a

G770.54

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 43

G770.54 Registered No.

1. NAME OF DECEASED (Type or Print) MRS. ANNA G. GRIBBIN

2. DATE OF DEATH August 6 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3909 Northern Parkway

c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-05
D. STREET ADDRESS (If rural, give location) 3909 Northern Parkway

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W	Widowed	April 7, 1865	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Maryland	—

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Andrew Knell	Sophie Jungman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	James E. Gribbin	3909 Northern Pkwy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Congestive Heart Failure	2 days
DUE TO		
(B)	Cardio-Vascular Hypertension Disease	10 years
DUE TO		
(C)	Arteriosclerosis	10 years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
		WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 4, 1947, *to* August 6, 1949, *that I last saw the deceased alive on* August 5, 1949, *and that death occurred at* 12:55 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Michael J. Dauch M. D.	4636 Belair Road	August 6 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-7-49	Cathedral	Baltimore

DATE RECEIVED BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	George A. Farley - Father and Fight	

VS 150

93D

77055

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77055

Registered No.

1. NAME OF DECEASED (Type or Print) EDWARD ROTH

2. DATE OF DEATH AUG. 6, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) GOOD SAMARITAN NURSING HOME

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 811 MADISON AVE.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	WIDOWED	FEB. 11, 1890	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		CHESTER, PA.	

13. FATHER'S NAME
FRANK ROTH

14. MOTHER'S MAIDEN NAME
AGNES McCLURG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
MRS. HENRY NIEBERDING, ROSEDALE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO (B) & Myocardial degeneration

DUE TO (C) Generalized Arterio sclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Premature Senile Psychoses — ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 1, 1949, *to* August 6, 1949, *that I last saw the deceased alive on* August 5, 1949, *and that death occurred at* 2.30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Melvin N. Borden M. D.	2030 W. Fayette St	8/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
BURIAL	8-9-49	HOLY REDEEMER	BEL AIR RD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	C. Charles L. Zeiler	901 S. Conkling St.

VS 150

G770:56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

Registered No. G770:56

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Kunigunda Schumm

2. DATE OF DEATH August 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

c. Length of stay in Baltimore 61 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City 26-08
D. STREET ADDRESS (If rural, give location) 3906 Mt. Pleasant Avenue #2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	4-24-68	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House-Work	At Home.	Germany	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Schumm	Anna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Katherine Hesse	2754 Alameda Blvd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cerebro vascular accident	3 days
	DUE TO	
ANTECEDENT CAUSES	(B) Hypertensive cardiovascular disease	?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C) + Arteriosclerotic cardiovascular disease	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Left hem. plegia	3 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-4 1949 *to* 8-6, 1949 *that I last saw the deceased alive on* 8-6, 1949, *and that death occurred at* 1125 A *m., from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
Marguerite Louise Candler	Md. General Hospital	8/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-9-49	Sacred Heart Cem.	German Hill Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	Charles S. Zeiler	901 S. Conkling St.

VS 150

93D

G770:57

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

45 Registered No. G770:57

1. NAME OF DECEASED (Type or Print): Ethel Ward

2. DATE OF DEATH: 8-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital Calvert & Dolphin Sts

C. Length of stay in Baltimore: 45 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): Bare Hill - Falls Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	Jan. 2 1904	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: George Washington Ward

14. MOTHER'S MAIDEN NAME: Mary Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Richard Ward ADDRESS: Bare Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malignant nephro sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

(B) Uremia, — 1 week

DUE TO

(C) Hypertension malignant

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypostatic pneumonia, cellulitis of

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-14-49		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-8, 19 49 *to* 8-6, 19 49, *that I last saw the deceased alive on* 8-6, 1949, *and that death occurred at* 3 10 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Richard Ward, M. D.	Mercy Hospital	8/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Aug. 9 1949	Woodstock, Md.	Woodstock, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	Holland Funeral Home	1631 West Fayette Ave.

VS 150

131a

G770:58

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

Registered No. G770:58

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edward Lee Watts

2. DATE OF DEATH Aug. 6 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Brady 2

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-07

D. STREET ADDRESS (If rural, give location) 1406 Druid Hill Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	Colored		4-12-15	34		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur		Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Watts	Emma Shipley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Pulmonary infiltration.

DUE TO

(B) Hypernephroma of Right Kidney

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/23/49 *to* 8/6/49, *that I last saw the deceased alive on* 8/6/49, *and that death occurred at* 10:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. deBerk M. D.	JOHNS HOPKINS HOSPITAL	8/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 10, 1949	Arbutus Mem. Plc.	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, MD	Holland Funeral Home	1631 Druid Hill Ave.

VS 150

52a

BIRTH NO. 7059 130847

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77059

1. NAME OF DECEASED (Type or Print): Arpheleus Allen

2. DATE OF DEATH: 8- 6- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave.
c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: 14-03
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 514 Bloom St. ~~Crownsville State Hospital~~ over

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Married	Jan. 31, 1924 ?	25 26 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10B. KIND OF BUSINESS OR INDUSTRY: Aeroplane
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ?Joseph Allen
14. MOTHER'S MAIDEN NAME: Gertrude Allen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records B.C.H. ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Anesthesia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Schizophrenia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8- 6-, 1949, *to* 8- 6-, 1949, *that I last saw the deceased alive on* 8- 6- 19 49, *and that death occurred at* 8.20 Am, *from the causes and on the date stated above.*

23A. SIGNATURE: L. S. Rogers M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 8-6- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/9/1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Pk.
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1031 Druid Hill Ave.

To Be Approved By The Chief Medical Examiner.

VS 150

84B

77060

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

012.0 G77060

Registered No.

1. NAME OF DECEASED (Type or Print): Adelade Maxwell

2. DATE OF DEATH: Aug. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 909 N. Gilmor St.

C. Length of stay in Baltimore: 67-Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16 or
D. STREET ADDRESS (If rural, give location): 909 N. Gilmor St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colred	Widowed	Aug. 12, 1885	63 67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	U. S. A.

13. FATHER'S NAME: James Crispin

14. MOTHER'S MAIDEN NAME: Adelade O'Neil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Lillian Beasley ADDRESS: 909 N. Gilmor St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia (Prob. Thrup) — INTERVAL BETWEEN ONSET AND DEATH: 72-96 hrs

DUE TO

(B) Psoas Abscess (PSOAS) — Undet

DUE TO

(C) undetermined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes, Malnutrition,

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 25, 1949, *to* Aug 6, 1949, *that I last saw the deceased alive on* Aug 6, 1949, *and that death occurred at* 9 30 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Harland Russell Jr. M. D.	902 W. Franklin St	8-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 10, 1949	Mt. Auburn	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Hunter for Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave 16

VS 150

770.1 **CERTIFICATE CORRECTED** 8-18-49 ✓ G77061

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Lessie Nash

2. DATE OF DEATH: August 7, 1949

3. PLACE OF DEATH
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-10
D. STREET ADDRESS (If rural, give location): 4434 St. Georges Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	6-1-[illegible]	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		N Carolina	

13. FATHER'S NAME: William Williams

14. MOTHER'S MAIDEN NAME: Diane Bacon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumothorax, ? tense,
DUE TO valvular, etiology
(B) undetermined, but possibly
DUE TO Tuberculosis.
(C) arthritis, probably rheumatoid,
multiple & flexion contractures

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	FLEXION CONTRACTURES	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-7, 1949 *to* 8-7, 1949 *that I last saw the deceased alive on* 8-7 1949, *and that death occurred at* 9:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ralph H. Schroeder M. D.	JOHNS HOPKINS HOSPITAL	8/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 11, 1949	Arbutus Mem. Pk.	Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	Holland Funeral Home	160 Druid Hill Ave.

VS-150

13B

770.2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Dist. No. 1 G770.2 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) David Schapiro

2. DATE OF DEATH Aug. 8/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 4613 Park Heights

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 61 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BAtimore

D. STREET ADDRESS (If rural, give location) 3703 Dennlyn Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Dec. 1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	None	Russia	

13. FATHER'S NAME: Laib Schapiro

14. MOTHER'S MAIDEN NAME: Hannah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Annie Schapiro 3703 Dennlyn Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary infarction

DUE TO

(B) Ch myocarditis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/5 *19*49*, to* 8/7 *, 19*49*, that I last saw the deceased alive on* 8/7 *, 19*49*, and that death occurred at* 8:30 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE G. L. Horwitz M. D.

23B. ADDRESS 704 E. Biddle St

23C. DATE SIGNED 8/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 9/49	Hebrew Young Men	Windsor Mill Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 9 1949	Huntington Williams, M.D.	Sol Levinson & Bros. 1126 W. North Ave.

VS 150

937

CERTIFICATE CORRECTED 8-9-49 ✓

G770:3 — 45 — G770:3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): BERNARD L. AHMAN, JR.

2. DATE OF DEATH: 7 AUGUST 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: UNION MEM. HOSP.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
c. Length of stay in Baltimore: ~~NOT KNOWN~~ 18 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALT.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 107 E. 32ND ST. 17 07

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 12 JULY 1911
9. AGE (In years last birthday): 38
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~ADMINISTRATOR~~ ~~Chief Engineer~~ Hydraulic Engineer
10B. KIND OF BUSINESS OR INDUSTRY: ~~BOARD OF SEWERS~~ State Department Service
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: BERNARD L. AHMAN, SR.
14. MOTHER'S MAIDEN NAME: ANNIE McKOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): UNK.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: UNK. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 1 MO.
DUE TO
(B) HYPERTENSIVE RENAL VASCULAR DISEASE — .?
DUE TO
(C) MALIGNANT HYPERTENSION — 9 YRS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 27, 1949, *to* August 7, 1949 *that I last saw the deceased alive on* August 7, 1949 *and that death occurred at* 8 35 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE: Harry L Shadden Jr M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: August 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/9/49
24C. NAME OF CEMETERY OR CREMATORY: St Mary's
24D. LOCATION (City, town, or county) (State): Norfolk Va

DATE RECEIVED BY LOCAL REGISTRAR: AUG 9 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: Wilson & Co Inc
ADDRESS: 1217 Eutaw St

VS 150

131a

G770-4

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G770-4

1. NAME OF DECEASED (Type or Print) Yingue, Elsie Aymar

2. DATE OF DEATH Aug 7, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital.

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 41 S. Fulton Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Fe	White	Divorced	8/25/1898	50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	At Home	Maryland	U.S.A.

13. FATHER'S NAME John Ambrose

14. MOTHER'S MAIDEN NAME Minnie Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Coronary Arteriosclerosis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 2, 1949, *to* Aug 7, 1949, *that I last saw the deceased alive on* Aug 7, 1949 *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo Balmere, M. D.	Franklin Sq Hosp	8-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/10/49	Mt. Olivet	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	Wm Cook Inc.	127 St. Paul St

VS 150

94a

G770-5 ✓ 50.0 G770-5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print) Cornelius Allen Tyler

2. DATE OF DEATH ~~10:15 p.~~ August 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 152 S. Hilton St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 0

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 152 S. Hilton Street 20-07

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Married	5/5/876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Owner	Auto. Service Station	Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel A. Tyler	Cassandra Gootee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Katie Tyler	152 S. Hilton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Arteri-Sclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L. Royer M.D.		

24A. BURIAL, ~~CREMATION, REMOVAL (Specify)~~	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	8/10/49	Green Lawn	Cambridge Md.

DATE RECEIVED BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	Wm Cook Inc	1217 St. Paul St.

VS 151

93D

G770:6

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 G770:6

Registered No.

1. NAME OF DECEASED (Type or Print) **Louis T. Lear**

2. DATE OF DEATH **Aug. 6/49**

3. PLACE OF DEATH
A. Baltimore City, Maryland **Balto.Md.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **1700 N. Aisquith St.**

C. Length of stay in Baltimore **Life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **1700 N. Aisquith St.** 9-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Nov. 3, 1866	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber	Own Business	Balto. Md.	

13. FATHER'S NAME **Herman Lear**

14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Mary L. Lear	1700 N. Aisquith St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypertension + arteriosclerotic cardio-vascular disease	1 year
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Bronchopneumonia	2 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 1949 *to* 8.6 1949, *that I last saw the deceased alive on* 8.5 1949 *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. H. Kramer M. D.	1402 E. Fairmount St.	8.8.49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 9/49	Lorraine Pk. Woodlawn	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	Harry A. Wiltze	4101 Edmondson Ave.

VS 150

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G770:7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176

G770:7

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Florence L. Batchelor Batchelor

2. DATE OF DEATH 7 Aug 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Yes

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore 61 yrs (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore Cnty
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City 20-08
D. STREET ADDRESS (If rural, give location) 3342 Strickland St

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH 4/13/1888 | 9. AGE (In years last birthday) 61 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | 10B. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frances Moore | 14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Estelle Smith ADDRESS 3342 Strickland St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Squamous Cell Carcinoma of Vulva — DUE TO — 2½ yrs

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION Oct 1947-Oct 1949 | 19B. MAJOR FINDINGS OF OPERATION Squamous Cell Carcinoma of Vulva | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1948 *to* 7 Aug 1949, *that I last saw the deceased alive on* 2 Aug 1949, *and that death occurred at* 9:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Joseph A. Bogut M. D. | 23B. ADDRESS University Hospital | 23C. DATE SIGNED 7 Aug 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/10/49 | 24C. NAME OF CEMETERY OR CREMATORY Mt Olivet Cem | 24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 9 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Robt C. & B. M. Walters ADDRESS Strickland St

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G7708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G7708

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Howard Scarborough

2. DATE OF DEATH: 8-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 636 S. Potomac Street. 1-07

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 10, 1898
9. AGE (In years last birthday): 51
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Scarborough
14. MOTHER'S MAIDEN NAME: Mary Repp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Upper respiratory hemorrhage Hemorrhage From Esophogeal Varicoses
DUE TO
(B) Pul. Tuberculosis, advanced
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II cirhotic Fatty Infiltration of Liver
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bilateral Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

(over)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-7- , 1949, *to* 8-8- , 1949, *that I last saw the deceased alive on* 8-8 1949, *and that death occurred at* 12:15 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 8-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 11 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cem
24D. LOCATION (City, town, or county) (State): Balto. County

RECEIVED BY REGISTRAR: AUG 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John H. Weber ADDRESS 401 S. Chester St

VS 150

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BIRTH NO. 3 31

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) JAMES SINGLETON

2. DATE OF DEATH Aug 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 607 Pennsylvania Avenue
C. Length of stay in Baltimore 25 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 607 Pennsylvania Avenue

17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Separated	July2, 1899	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Bladenboro, N.C.	U.S.A.

13. FATHER'S NAME Luther Singleton

14. MOTHER'S MAIDEN NAME Nora ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Thurmond Singleton-607	Penna. Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	8 Hrs
DUE TO (B)	Hypertension, Es.	?
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Congestive Heart Failure &	Year
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Auricular Fibrulation	Year

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1946 *to* Aug.6, 1949, *that I last saw the deceased alive on* Aug.6, 1949, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry McDonald M. D.	844 N.Carey St.	8/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/10/49	Mt Calvary	Bladenboro N.Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 9 1949	Huntington Williams, M.D.	A. HALSTEAD-918 Druid Hill Ave-1

VS 150

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770.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G770.0

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MILDRED E. PFAFF

2. DATE OF DEATH Aug 7. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1002 Scott St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived) (If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1002 Scott St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	July 11. 1900	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor

10B. KIND OF BUSINESS OR INDUSTRY L. Grif. Clothing

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Scheer

14. MOTHER'S MAIDEN NAME Caroline Anacker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-01-6919

17. INFORMANT John L. Pfaff ADDRESS 1002 Scott St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 da

DUE TO

(B) Coronary Disease Phlebitis Left leg — 2 wks

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/24 1949 to 8-7 1949 *that I last saw the deceased alive on* 8/7 1949 *and that death occurred at* 11:30 a. m. *from the causes and on the date stated above.*

23A. SIGNATURE Joseph L Pfaff M. D. | 23B. ADDRESS 629 Washington Blvd | 23C. DATE SIGNED 8/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug 10. 1949 | 24C. NAME OF CEMETERY OR CREMATORY Western | 24D. LOCATION (City, town, or county) (State) Balto City

DATE RECEIVED BY REGISTRAR AUG 9 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Mrs. John W. Pfaff & Son ADDRESS 5311 Edmondson Ave

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G770.1 130377 CERTIFICATE CORRECTED 8-9-49 ✓

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 no. 0

Registered No. G770.1

1. NAME OF DECEASED (Type or Print) Warren (Daugherty) Dougherty

2. DATE OF DEATH 8- 5- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1713 (762) W. LOmbard ST. 19 04

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Septl 28-(1880) AGE (In years last birthday): 68 (62) Yrs. If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Display Adv.-Service Dept. - Balto New-Post
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ? George W. Dougherty
14. MOTHER'S MAIDEN NAME: Georgianna Dunn (Georgetta Daugherty)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-16-5673
17. INFORMANT ADDRESS: Records B.C.H. 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Arteriosclerotic heart disease
DUE TO with generalized arteriosclerosis
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: over

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7- 17- 30 1949 *to* 8- 5- , 1949 *that I last saw the deceased alive on* 8- 5- 1949 *and that death occurred at* 5.50 P m., *from the causes and on the date stated above.*

23A. SIGNATURE P. S. Hagen, M. D.
23B. ADDRESS B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED 8-8- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 10" 1949
24C. NAME OF CEMETERY OR CREMATORY Mt Olivet Cem
24D. LOCATION (City, town, or county) (State) Baltimore Md
25. FUNERAL DIRECTOR Willis Donovan
ADDRESS 4510 Liberty Heights Ave

DATE RECEIVED BY LOCAL REGISTRAR: AUG 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

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G770?2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G770?2

BIRTH NO. B.C. 49-16234 Registered No.

1. NAME OF DECEASED (Type or Print) Joseph Edward Neville	2. DATE OF DEATH 8-9-49
3. PLACE OF DEATH: A. Baltimore City, Maryland 2025 W. Fayette St.	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital	B. COUNTY
c. Length of stay in Baltimore Yrs. Mos. Days	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 29.
	D. STREET ADDRESS (If rural, give location) 9 S. Beechfield Ave. 28-04
5. SEX M.	6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 8/8/49
9. AGE (In years last birthday)	If Under 1 Year: Months / Days
If Under 24 Hours: Hours 15 Min. 45	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joseph Henry Neville	14. MOTHER'S MAIDEN NAME Mary Bernadette Ward
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RESPIRATORY FAILURE

DUE TO

(B) PREMATURITY

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 8, 1949, *to* Aug 9, 1949 *that I last saw the deceased alive on* Aug. 8, 1949, *and that death occurred at* 5:50 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE Paul A. Manning M. D.	23B. ADDRESS Bon Secours Hospital	23C. DATE SIGNED 8/9/49
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Aug 9-49	24C. NAME OF CEMETERY OR CREMATORY Holy Cross
24D. LOCATION (City, town, or county) (State) Balto Co. Md.		
DATE RECEIVED BY LOCAL REGISTRAR AUG 9 1949	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR ADDRESS H. Billingsley & Son 1300 Eutaw

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77073
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 9 16 G 77073
Registered No.

1. NAME OF DECEASED (Type or Print): MARTIN WRIGHT — N-9482
2. DATE OF DEATH: August 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital (d.o.a.)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 125 S. Highland Avenue 26-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	divorced	Nov. 1888	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	U.S.Goverment	Baltimore	

13. FATHER'S NAME: David Wright Sr.
14. MOTHER'S MAIDEN NAME: Hannah Haseneii

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			David Wright Jr. 125 S. Highland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) 2nd - 3rd ° burns entire — INTERVAL BETWEEN ONSET AND DEATH: Instantly
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	125 S. Highland Avenue 26/8

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 6, '49 a m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Fire confined to bedroom (Origin unknown)

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Emil C Bruger M.D.
23B. CHIEF MEDICAL EXAMINER ☐ / ASSISTANT MEDICAL EXAMINER ☐ / MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 8 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/8/49	Oak Lawn	7225 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR / ADDRESS: Clarence F. Hoffmann 1639 Broadway.

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180

BIRTH NO. 770.74

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 Registered No. G770.74

1. NAME OF DECEASED (Type or Print): John Bauernfeind

2. DATE OF DEATH: Aug. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 302 S Eaton St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 302 S Eaton St.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 302 S. Eaton St. 26-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Nov. 28, 1871	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		Baltimore	

13. FATHER'S NAME: Christopher

14. MOTHER'S MAIDEN NAME: Sabina Berl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Margaret Bauernfeind 302 S. Eaton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-
DUE TO Vascular Renal Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 9, 1949 *to* Aug 5, 1949, *that I last saw the deceased alive on* Aug 1, 1949, *and that death occurred at* 1P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward A. Flanagan Jr. M.D. M. D.	3503 Fait Ave	8-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/9/49	Oak Lawn	7225 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
AUG 9 1949	Huntington Williams, M.D.	Clarence F. Hoffmann 1639 Broadway.

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7075

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77075

1. NAME OF DECEASED (Type or Print): Michael A. McNamara

2. DATE OF DEATH: Aug. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1105 Wilcox St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1105 Wilcox St. 10-01

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 29, 1885
9. AGE (In years last birthday): 64 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Robinson Oil Co.

11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Margaret E. McNamara 1105 Wilcox St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B) Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/26, 1948 *to* 8/8, 1949 *that I last saw the deceased alive on* 8/3, 1949 *and that death occurred at* 8 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph L. Blum M. D.
23B. ADDRESS: 1110 E. Calvert St.
23C. DATE SIGNED: 8/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. 11, 1949
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): North Ave & Rose St.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 9 1949
REGISTRAR'S SIGNATURE: Thurston Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Clarence F. Hoffmann 1639 Broadway

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70-76

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

416

G770-76 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CONSTANCE F. BERKENKEMPER

2. DATE OF DEATH August 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 800 S. Bond Street Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 800 S. Bond, St
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Essex,
D. STREET ADDRESS (If rural, give location) 925 Renfrew Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	Oct. 24-1922	26				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Peter Drymala
14. MOTHER'S MAIDEN NAME Lucy Oles.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. (INFORMANT) Warren Berkenkemper ADDRESS 925 Renfrew St. East Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic heart disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED August 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 11. 1949	St. Stanislaus	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 9 1949
REGISTRAR'S SIGNATURE [illegible] Washington Williams, M.D.
25. FUNERAL DIRECTOR Wm. L. Fialkowski ADDRESS 2007 Eastern Ave

VS 151

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7707 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 43 Registered No. G7707

1. NAME OF DECEASED (Type or Print) Matilda Caldwell

2. DATE OF DEATH August 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 425 Henrietta St.

C. Length of stay in Baltimore 45 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 425 W. Henrietta Street 21-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	Colored	Widow	June 15, 1899	50	1 / 20	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Westmoreland Co. VA.	U.S.A.

13. FATHER'S NAME James Parker

14. MOTHER'S MAIDEN NAME Jane Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Ruth Bilton.,	425 Henrietta St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Congestion — Several days

DUE TO

(B) Acute Gastritis — Several weeks

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 29, 1949, to August 5, 1949, that I last saw the deceased alive on August 5, 1949, and that death occurred at 11:15A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard H. Hunt M. D.	1631 W. Franklin St	8-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 10, 1949	Mt Calvary	Cedar Hill, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Cuntington Williams, M.D.	Mrs Katie R. Williams	322 N

VS 150

118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 7078 — Registered No. 7078

1. NAME OF DECEASED (Type or Print) AUGUSTUS Johnson mp

2. DATE OF DEATH August 6, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

A. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 918 West Franklin Street 18-01

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: May 3, 1905
9. AGE (In years last birthday): 44 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Hammond

14. MOTHER'S MAIDEN NAME: Stella Johnson.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Blanche Butler 918 W. Franklin St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Emil L Krieger M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED Aug 7 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 11, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams — ADDRESS 322 N. Schroeder St

VS 151

94a

70/9 JL - 130646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 9-7

G770/9 Registered No.

BIRTH NO. -

1. NAME OF DECEASED (Type or Print) William Farrell

N-8-0

2. DATE OF DEATH 8-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
16-04
D. STREET ADDRESS (If rural, give location) ~~Crownsville State Hosp.~~ 1945 Harlem Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	Negro	Single ?	March 1883	66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		?	

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		B. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Recent Infarction of Myocardium - Left Ventricle — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CERTIFICATION APPROVED BY

M.D.
CHIEF OR ASST. MEDICAL EXAMINER

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Infarction Left Lower Lobe- Lung

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Aug. 1, 1949	S. P. Nail Hip	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Crownsville	Crownsville State Hospital

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
7-28-49 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	Fell out of bed

22. *I hereby certify that I attended the deceased from* 7-28-49, 19__ *to* Aug. 7, 19 49 *that I last saw the deceased alive on* Aug. 7, 19 49 *and that death occurred at* 7.55 PM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. S. Rogers M. D.	4940 Eastern Ave.	8-8-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 10, 1949	Mt Auburn	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	Geo. C. Kelson	1303 Pressman St.

VS 150

To be approved by Medical Examiner.

186a

77080

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E8-4 4 G77080 Registered No.

1. NAME OF DECEASED (Type or Print) BERNARD N. MORRIS N-803 ✓

2. DATE OF DEATH August 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Franklin Square Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1704 Parker Court 1-6-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	colored			22				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

DUE TO

(B) Intracranial Hemorrhage

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] ~~CAUSE OF~~ DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Wilkens Ave. and Fulton Ave. 19/4

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 7, 1949 7 p. m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Fell off cab of truck while in motion

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE Carl L. Reyer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED August 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Aug. 11, 1949

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary

24D. LOCATION (City, town, or county) (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 9 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Geo. G. Kelson 1303 Presstman St.

VS 151

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G77081

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59

G77081

Registered No. 55909

1. NAME OF DECEASED (Type or Print) George BROCKMEYER

2. DATE OF DEATH Aug. 8-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. Length of stay in Baltimore ? Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-01
D. STREET ADDRESS (If rural, give location) 5131 Benton Heights Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	Single	11-23-1908	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk ?	?	Maryland	U.S.A.

13. FATHER'S NAME Gregory Brockmeyer

14. MOTHER'S MAIDEN NAME Annie Kramer.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.
No.		?

17. INFORMANT Mrs Anna Benda, ADDRESS 2020 E. Lombard

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Chronic glomerular nephritis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 30, 1949 *to* August 8, 1949, *that I last saw the deceased alive on* August 8 1949, *and that death occurred at* 5 1/2 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nikat J. Lencka M. D.	St. Agnes Hospital	8/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/11/49	Holy Redeemer	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	Leonard J. Luck	5305 Harford Rd.

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077082

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77082

1. NAME OF DECEASED (Type or Print): ROBERT E. LLOYD

2. DATE OF DEATH: August 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hosp. (doa)
C. Length of stay in Baltimore: 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 38 N. Bentalou Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Widowed	Jan. 8. 1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Boiler Maker
10B. KIND OF BUSINESS OR INDUSTRY: B. & O. R.R.
11. BIRTHPLACE (State or foreign country): VA
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Nathaniel Lloyd
14. MOTHER'S MAIDEN NAME: Rose Eisenhart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: C. Edgar Hearn, Jr. ADDRESS: 805 Mt. Holly St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Nephrolithiasis
DUE TO
Pyelonephritis.
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST:

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George A. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 8/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8.9.49	Lorraine Park	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: G. Howard Strong ADDRESS: 3207 W. North Ave

VS 151

C. 131a

~~77083~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Vol. 1 G77083

BIRTH NO. ~~77083~~ Registered No.

1. NAME OF DECEASED (Type or Print) INMAN CRAIG

2. DATE OF DEATH 5 AUG 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Hospital 27 N. Carey St.

C. Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 726 Asquith St. 10-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored	Widower	Sept. 15, 1893	56 [redacted] EMS		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Warrenton, Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Lawson Craig

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Inman Craig Jr. ADDRESS 726 Asquith St. Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: —

DUE TO

ANTECEDENT CAUSES

(B) Marked arteriosclerosis

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) and coronary insufficiency

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 20 July 1949 *to* 5 Aug 1949, *that I last saw the deceased alive on* 5 Aug 1949 *and that death occurred at* 9:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Emil H. Henning Jr. M. D.	4580 Edmondson Ave	6 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 9, 1949	Mt. Calvary	Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	Joseph L. Russ	1205 McCulloh St. Baltimore, Md.

VS 150

94a

G77084

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

141 X

Registered No. G77084

1. NAME OF DECEASED (Type or Print): William Borland King

2. DATE OF DEATH: 8-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 812 Belgian Ave

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 812 Belgian Ave 7-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Dec. 13, 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10B. KIND OF BUSINESS OR INDUSTRY: Sun Paper

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wm. J. King

14. MOTHER'S MAIDEN NAME: Clara F. Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Cora King ADDRESS: 812 Belgian Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of tongue & left cervical region — INTERVAL BETWEEN ONSET AND DEATH: 15 mos

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: X-ray and irradiation treatments

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 1, 1949 *to* Aug. 8, 1949 *that I last saw the deceased alive on* Aug 6, 1949 *and that death occurred at* 8.45A *m., from the causes and on the date stated above.*

23A. SIGNATURE: J. Willis Guyton M.D. M. D.

23B. ADDRESS: 3961 Greenmount Ave

23C. DATE SIGNED: 8/9/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 8-11-49

24C. NAME OF CEMETERY OR CREMATORY: Greenmount

24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 9 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John A. Moran ADDRESS: 3000 E. Balt St

VS 150

45B

G77085
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77085

1. NAME OF DECEASED (Type or Print): ELMER SAMPSON

2. DATE OF DEATH: Aut. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1036 Argyle Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1036 Argyle Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Male	Colored	Married

8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Oct.4,1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Stenenson Sampson
14. MOTHER'S MAIDEN NAME: Laura Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: M's Isabelle Sampson ADDRESS: 1036 Argyle Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.)

(A) Cerebral Hemorrhage
DUE TO
(B) Coronary Heart Disease ?
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-1, 1949 to 8-7, 1949 *that I last saw the deceased alive on* 8-7, 1949 *and that death occurred at* 1.00 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 867 Hollins Bldg
23C. DATE SIGNED: 8-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-11-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvery Cem
24D. LOCATION (City, town, or county) (State): Anne Arundel Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Frances A. Hemsley ADDRESS: 578 W. Biddle

94a

G77086 Perkins G77086

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 443

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Nellie Perkins. 2. DATE OF DEATH August 9, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Mercy Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
C. Length of stay in Baltimore 46 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1018 Hillen St. 10-01

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH June 14, 1888 | 9. AGE (In years last birthday) 61 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Talbot Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Unknown Peyton C. Gay
14. MOTHER'S MAIDEN NAME Unknown Sarah, Faulkner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Husband ADDRESS 1018 Hillen St. Easton Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 5 Yrs.
DUE TO
(B) Hypertensive Cardio. Vasc. Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypertensive.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 7 1949 *to* Aug 9 1949, *that I last saw the deceased alive on* Aug 9 1949, *and that death occurred at* 11:15 m., *from the causes and on the date stated above.*

23A. SIGNATURE Mary E. Methvin M. D. | 23B. ADDRESS Mercy Hosp. | 23C. DATE SIGNED Aug 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug. 11, 1949 | 24C. NAME OF CEMETERY OR CREMATORY SpringHill | 24D. LOCATION (City, town, or county) (State) Easton, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 9 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Stewart & Mowen Co. | ADDRESS 108 W. North ave. Balto. Md. 63B

VS 150

177087

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 177087

1. NAME OF DECEASED (Type or Print) Wilton A. Thompson — 2. DATE OF DEATH August 7, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Turners Station
D. STREET ADDRESS (If rural, give location) 141 Carver Road

5. SEX Male — 6. COLOR OR RACE Colored — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH April 25, 1917 — 9. AGE (In years last birthday) 32 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Mill — 10B. KIND OF BUSINESS OR INDUSTRY Beth-Steel, Sparrows Pt.

11. BIRTHPLACE (State or foreign country) Lumberton, N. C. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Will O. Thompson — 14. MOTHER'S MAIDEN NAME Amelia McNeil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) War # 2 (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. 239-14-6739

17. INFORMANT Juanita Thompson — ADDRESS 141 Carver Rd. Turners Station

c. Length of stay in Baltimore: 3 Yrs. Mos. Days

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Route 151, North Pt. Hiway. & Sparrows Pt. Rd.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY. July 7, 1949 Approx. 1:30 a. m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Auto. overturned -- deceased passenger

22. *I certify that I took charge of the remains described above, held an* Autopsy / Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Emil H. Beyer M.D. — 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ — 23C. DATE SIGNED Aug 9

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE Aug. 11-49 — 24C. NAME OF CEMETERY OR CREMATORY Moore Sanding Cem. — 24D. LOCATION (City, town, or county) (State) Lumberton N C

DATE RECEIVED BY LOCAL REGISTRAR AUG 9 1949 — REGISTRAR'S SIGNATURE Huntington Williams, MD — 25. FUNERAL DIRECTOR Elroy O. Wilson — ADDRESS 1000 Brantley Ave

VS 151

170c

G77088

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

571.0

Registered No. G77088

1. NAME OF DECEASED (Type or Print) WILMA LEE OSBORNE

2. DATE OF DEATH AUG 9, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL
c. Length of stay in Baltimore Yrs. Mos. Days after 3 hrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY CARROLL
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) FINKSBURG
D. STREET ADDRESS (If rural, give location) Rt. 1.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	SINGLE	MARCH 26, 1949		4	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY: INFANT

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: MORGAN OSBORNE

14. MOTHER'S MAIDEN NAME: LINDA JANE FORD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MOTHER ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DEHYDRATION & ACIDOSIS — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

DUE TO

(B) VOMITING & DIARRHEA

DUE TO

(C) UNKNOWN

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* AUGUST 9, 1949 *to* AUGUST 9, 1949 *that I last saw the deceased alive on* AUGUST 9, 1949 *and that death occurred at* 9:00 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edmund B. Middleton, M. D.	UNIVERSITY HOSPITAL	August 9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/11/49	Angel Cem.	Jonesville, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	Edw. Faulson	2359 Nash Place

119a

77089

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77089

Registered No.

1. NAME OF DECEASED (Type or Print) Jennie B. McGill

2. DATE OF DEATH August 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6020 Sefton Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 1 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 6020 Sefton Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Sept. 30, 1867	81 83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Pennsylvania	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Aaron Hill	? Sessnery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. L. R. Colbert	6020 Sefton Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the uterus — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Dec. 9, 1949	Biopsy - carcinoma of cervix of uterus	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* November 22, 1948 *to* August 9, 1949, *that I last saw the deceased alive on* August 9, 1949, *and that death occurred at* 11:45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	6217 Harford Rd	8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	8 - 12 - 49	Mount Auburn	Dunbar, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	John O. Mitchell & Sons, Inc.	1900 Eutaw Place

Mallon B. Mitchell 48a

VS 150

G77090

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170

Registered No. G77090

1. NAME OF DECEASED (Type or Print) ESTELLA LEWENSOHN

2. DATE OF DEATH Aug 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3815 Clifton Ave

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE COUNTY 3815 Clifton ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md
D. STREET ADDRESS (If rural give location) 3815 Clifton ave 15-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	If under 1 year: Days	If under 24 hours: Hours	If under 24 hours: Min.
Female	White	Single	Feb 2 1883	66	8	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Balto Md	

13. FATHER'S NAME Meyer Lewensohn

14. MOTHER'S MAIDEN NAME Rosa Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT Carolyn Lewensohn ADDR. Clifton 1935

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary thrombosis	Sudden
DUE TO	Arteriosclerosis, general Hypertension	6 years +
(B)	Angina pectoris, Coronary sclerosis	13 years -
DUE TO		years -
(C)	Carcinoma of breast	10 years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from ____, 1939, to 7 Aug, 1949, that I last saw the deceased alive on 4 Aug, 1949, and that death occurred at 9:30 a. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis P. Hamburger Jr. M. D.	207 Eutaw St.	8 Aug 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 10 1949	Har Sinai Cemetery	Reisterstown Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949 VS 150	Huntington Williams, M.D.	David Sondheim's Son	1902 Eutaw Pl

50

G77091

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4th Registered No. G77091

1. NAME OF DECEASED (Type or Print) DAVID A. BREITSTEIN

2. DATE OF DEATH 9 AUGUST 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL
c. Length of stay in Baltimore UNK. 12 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALT.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) PIKESVILLE 8.
D. STREET ADDRESS (If rural, give location) OLD COURT ROAD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	M.	18 DEC 1895	53	7	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	Banker	VIRGINIA	USA

13. FATHER'S NAME: MR. CHARLES BREITSTEIN

14. MOTHER'S MAIDEN NAME: EMILY SPIEGEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
UNK		?	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 11 days

DUE TO

(B) Coronary thrombosis — 11 days

DUE TO

(C) Coronary atherosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 30 July 1949 *to* 9 AUGUST, 1949, *that I last saw the deceased alive on* 9 August, 1949, *and that death occurred at* 905 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. F. Cox 3rd M. D.	Union Memorial Hospital	8/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Aug 10/1949	Balto Hebrew	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 9 1949	Huntington Williams, M.D.	Wm. H. Lord Funeral Home	1002 Eutaw Pl

VS 150

94a

77092 G77092

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MARY C. CLISHAM
2. DATE OF DEATH: AUG. 7, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3910 HUDSON ST.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 26-09
D. STREET ADDRESS (If rural, give location): 3910 HUDSON ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	WIDOWED	JUNE 16, 1875	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	POLICE MATRON		U. S. A.

13. FATHER'S NAME: CHARLES H. HARTLEY
14. MOTHER'S MAIDEN NAME: BARBARA C. FLAHERTY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		MRS. JAMES HARTNETT SR.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Decompensation
DUE TO
(B) Myocarditis.
DUE TO
(C) Cardio Vascular Renal Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 6 1947 *to* Aug 7, 1949 *that I last saw the deceased alive on* Aug 6, 1949 *and that death occurred at* 1:45P *m., from the cause and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward G. Flanigan M.D.	3503 Fait Ave	Aug 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
BURIAL	8-10-49	NEW CATHEDRAL	Old Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Huntington Williams, M.D.	Charles S. Zeiler	901 S. Conkling St.

VS 150

131a

7093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77093

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DAVID HUGH HUGHES

2. DATE OF DEATH 8/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Darlington
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	6-4-1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Slate miner		Md.	U.S.

13. FATHER'S NAME Hugh Hughes

14. MOTHER'S MAIDEN NAME Catherine Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute arterio sclerotic heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Pulmonary fibrosis — years

DUE TO

(C) Silicosis — years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY, (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 5, 1949 *to* August 9, 1949, *that I last saw the deceased alive on* August 9, 1949, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. F. Cox 3d M. D.	Union Memorial Hospital	8/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-12-49	Glatorie	Delta Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Huntington Williams, M.D.	Hubert P. Harbine	Delta Pa.

VS 150

1142

7(594)-130669

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77094

1. NAME OF DECEASED (Type or Print): Frank Eagan

2. DATE OF DEATH: 8-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 137 Birchead Street (30) 24.03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	April 10, 1870	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Michael
14. MOTHER'S MAIDEN NAME: Catherine
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Pulmonary Edema
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Carcinoma of Prostrate with Metastasis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 1-27-44
19B. MAJOR FINDINGS OF OPERATION: Perineal Prostatectomy (Benign Prostatic Hypertrophy)
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-29, 19 49, *to* 8-8-, 19 49, *that I last saw the deceased alive on* 8-8, 19 49, *and that death occurred at* 11:40 A, *from the causes and on the date stated above.*

23A. SIGNATURE: O. S. Rogers M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 8-8-49

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify): Burial
24B. DATE: 8/11/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Holy Cross
24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 127 St. Paul St.

VS 150

51B

7095 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77095 Registered No.

1. NAME OF DECEASED (Type or Print): Milton C. Williams

2. DATE OF DEATH: Aug 6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Provident Hosp
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp
C. Length of stay in Baltimore: 18 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Cedar Hill. B. COUNTY: a a. Co. Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 221 Cedar Hill Lane Cedar Hill

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Widowed	July 26 1903	46	0	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	U. S. Chemical	a a. Co Md	

13. FATHER'S NAME: Rudolphus Williams
14. MOTHER'S MAIDEN NAME: Ella Jones
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-05-1884
17. INFORMANT: Ella Williams ADDRESS Cedar Hill Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 19 days
DUE TO
(B) Hypertension — 2-3 yrs
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/18 1949 *to* 8/6 1949 *that I last saw the deceased alive on* 8/6 1949 *and that death occurred at* 8:55 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Preston Grant M. D.	601 N. Carrollton	8/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City; town, or county) (State)
Burial	Aug 10-49	Mt. Calvary	a a. Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Thurlington Williams, M.D.	James Eastaye	142 Wilkes St

VS 150

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77096

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 6

G77096

Registered No.

1. NAME OF DECEASED (Type or Print): GENEVIEVE Polomski

2. DATE OF DEATH: 8-9-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1622 Clements St

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1622 Clements St. 2-4-01

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: March 3 19[illegible]
9. AGE (In years last birthday): 34
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY: ✓

13. FATHER'S NAME: Hippolit Polomski

14. MOTHER'S MAIDEN NAME: Pauline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Vincent Polomski ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia, Left. — INTERVAL BETWEEN ONSET AND DEATH: 8-7-49

DUE TO

(B) Inanition

DUE TO

(C) Lipomatosis, generalized. — I guess

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ✓

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-7 1949 *to* 8-9 1949, *that I last saw the deceased alive on* 8-9 1949 *and that death occurred at* 5 49 A M., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles B. MacDowell M. D.
23B. ADDRESS: 1213 Light St
23C. DATE SIGNED: 8-9-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: Aug. 11/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REG. AUG 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Fred W. Ozarowski ADDRESS: 1930 Boston St 108

VS 150

77097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77097

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FLORENTINE C. VERNON

2. DATE OF DEATH Aug. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1034 W. Barre St.
C. Length of stay in Baltimore Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1034 W. Barre St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
female	white	married

8. DATE OF BIRTH Nov. 8, 1897
9. AGE (In years last birthday) 51 yrs. If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress
10B. KIND OF BUSINESS OR INDUSTRY uniforms

11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Albert Froeb
14. MOTHER'S MAIDEN NAME Augusta Vorrath

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-18-0599

17. INFORMANT Mr. Louis Vernon ADDRESS 1034 W. Barre St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Liver
DUE TO
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH: 4 mos.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION July 1949
19B. MAJOR FINDINGS OF OPERATION Carcinoma of Liver
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1 1949 *to* Aug 8 1949, *that I last saw the deceased alive on* Aug 8, 1949, *and that death occurred at* 10 P *m., from the causes and on the date stated above.*

23A. SIGNATURE John P. Ulrich, Jr. M. D.
23B. ADDRESS 1227 Wash. Blvd
23C. DATE SIGNED 8-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/12/49
24C. NAME OF CEMETERY OR CREMATORY Balto. National Cem.
24D. LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 10 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR WM. J. TICKNER & SONS
ADDRESS Balto., Md.

VS 150

46F-

G77098

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77098

1. NAME OF DECEASED (Type or Print): TEMPERANCE LAURA BOWEN

2. DATE OF DEATH: Aug. 6, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1529 Sheffield Rd.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1529 Sheffield Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
female	white	married	Aug. 7, 1852	96 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore	

13. FATHER'S NAME: George Schroyer

14. MOTHER'S MAIDEN NAME: Nancy Hale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		no	Mrs. Velma A. Schrader	1529 Sheffield Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anaemia - Sec Enright
DUE TO Low Blood Pressure,
cardiac Asthenia.

(B)
DUE TO

(C) Metastatic surgery
carcinoma rectum and liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 5, 1949, *to* Aug 6, 1949 *that I last saw the deceased alive on* Aug 6, 1949, *and that death occurred at* 7 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D. Dr Elvi Coons	1202 St Paul St.	Aug 9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/10/49	Carroll Chapel Cem.	Balto. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Tunstington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

93E

7099 X ✓ 570.5 G77099

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77099

1. NAME OF DECEASED (Type or Print): MRS. AGNES LEONARD

2. DATE OF DEATH: 8/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BON SECOURS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTIMORE Dundalk
D. STREET ADDRESS (If rural, give location): 60 WILLOWSPRING RD.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	W.	M	9/19/92	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Christian Mullen
14. MOTHER'S MAIDEN NAME: Brigid Rabbitt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Howard M. Leonard ADDRESS 60 Willow Spring Rd. Dundalk

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CIRCULATORY FAILURE
DUE TO
(B) Severe toxemia
DUE TO
(C) Intestinal obstruction c probable peritonitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 8, 1949, *to* Aug. 8, 1949, *that I last saw the deceased alive on* Aug. 8, 1949, *and that death occurred at* 8:45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul D. Manning M. D.
23B. ADDRESS: Bon Secours Hospital
23C. DATE SIGNED: 8/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. 12, 1949
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart
24D. LOCATION (City, town, or county) (State): Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Roland L. Fisher, 2112 Dundalk Ave.

VS 150

122B

✓ 17°

G77100

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77100 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Leila Mothley - Lena M. MothLEY

2. DATE OF DEATH: 8:10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1903
D. STREET ADDRESS (If rural, give location): 1511 Ramsey STreet

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct 25-1874
9. AGE (If under 1 year or under 24 hours, last birthday): 75 — If under 1 year: Months / Days; If under 24 hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James L. Mothley
14. MOTHER'S MAIDEN NAME: Julia Geise
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Stephen Fillinux — ADDRESS: 1511 Ramsay St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
DUE TO
(B) Generalized CARCinomaTosis — 6 mos
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

over

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-5, 1949 *to* 8-10, 1949, *that I last saw the deceased alive on* 8-10, 1949, *and that death occurred at* 3:20 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: William J. Holloway M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 8-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/17/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto Md
25. FUNERAL DIRECTOR — ADDRESS: Roff & B. M. Walters Pratt & Stricker, Sts

DATE RECEIVED BY LOCAL REGISTRAR: AUG 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

777 G77101

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Henry Olds or Ohle

2. DATE OF DEATH 8- 4- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore Since 1888 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1420 W. Lexington ST. 1902

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH ? ? 1873
9. AGE (In years last birthday) 76 ? If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Wash. D.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Lewis
14. MOTHER'S MAIDEN NAME Laura

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Records B.CH. ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia Carcinoma of prostate
DUE TO
(B) ~~Hypertensive Arteriosclerotic Disease~~ ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10- 7- , 1924 *to* 8- 4- , 1949, *that I last saw the deceased alive on* 8- 4- 1949, *and that death occurred at* 4.50 Am., *from the causes and on the date stated above.*

23A. SIGNATURE T. S. Logan M. D.
23B. ADDRESS B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED 8-9- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/10/49
24C. NAME OF CEMETERY OR CREMATORY Sacred Heart
24D. LOCATION (City, town, or county) (State) German Hill Rd. ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR AUG 10 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR John J. Fahey & Sons 1318 Light St.

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77102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G77102

1. NAME OF DECEASED (Type or Print) JACOB ROTHSCHILD

2. DATE OF DEATH 8-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3629 Wabash Ave
c. Length of stay in Baltimore 10 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3629 Wabash Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	Married	15-11	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10B. KIND OF BUSINESS OR INDUSTRY Banking
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Jadar
14. MOTHER'S MAIDEN NAME Pauline
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Walter Rothschild ADDRESS 3629 Wabash Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Essential Hypertension — INTERVAL BETWEEN ONSET AND DEATH: 10 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Heart Disease — 2 years

DUE TO

(C) Congestive Ht failure — 1 day

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 5 1949 to Aug 9, 1949 that I last saw the deceased alive on Aug 9, 1949 and that death occurred at 6:20 P m., from the causes and on the date stated above.

23A. SIGNATURE Leonard Wallenstein M. D.
23B. ADDRESS 848 W 36th St
23C. DATE SIGNED Aug 10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8-10-49
24C. NAME OF CEMETERY OR CREMATORY Balto Hebrew
24D. LOCATION (City, town, or county) (State) Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 10 1949
REGISTRAR'S SIGNATURE Municipal Registrar
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eutaw Pl

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77103 G77103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANNA SCHOENFELT

2. DATE OF DEATH 8-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3203 Leighton Ave

C. Length of stay in Baltimore 40 Yrs. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3203 Leighton ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow		70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Not Known

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Meyer Chernock ADDRESS 3203 Leighton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary occlusion	1 hr.
DUE TO (B)	Arteriosclerotic ht. dis.	15 yrs.
DUE TO (C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 9 1935 *to* Aug 9, 1949, *that I last saw the deceased alive on* Aug 9 1949 *and that death occurred at* 9P m., *from the causes and on the date stated above.*

23A. SIGNATURE Irvin Barnes M. D.

23B. ADDRESS 3003 Jefferson Blvd

23C. DATE SIGNED Aug. 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8-11-49

24C. NAME OF CEMETERY OR CREMATORY Hebrew Mt Carmel

24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 10 1949

REGISTRAR'S SIGNATURE Thurlington for Williams, M.D.

25. FUNERAL DIRECTOR Jack Davis Inc

ADDRESS 2100 Eutaw Pl

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Minnie Brown

2. DATE OF DEATH 8-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ Hosp.
C. Length of stay in Baltimore — Yrs. 42 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1617 W. Mulberry Street 19-01.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	C	M	Oct. 12, 1893	55 56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H. W		Accomac County, Va.	

13. FATHER'S NAME: Obadiah Parker

14. MOTHER'S MAIDEN NAME: Maggie V. Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		1617 W.Mulberry Street Philip A. Brown Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Monocytic Leukemia
DUE TO Probable Cerebral Hemorrhage

(B)
DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes Mellitus

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-1, 1949, *to* 8-7, 1949, *that I last saw the deceased alive on* 8-7, 1949, *and that death occurred at* 8 45 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
P. G. Swoope Jr. M. D.	Univ. Hosp.	8-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 11, 1949	Mt. Calvary	Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 10 1949	Huntington Williams, MD	Charles H. Alexander 1200 McCulloh St., Baltimore, Md.

VS 150

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G77105

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77105

1. NAME OF DECEASED (Type or Print): Joseph Mascari

2. DATE OF DEATH: 8/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: 55 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 254 S. Exeter 3-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Male	white	married	Aug. 15, 1870	78	11	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Italy	U.S.A.

13. FATHER'S NAME: Joseph Mascari

14. MOTHER'S MAIDEN NAME: [illegible] Maria Scecola

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Teresa Mascari ADDRESS: see above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis, origin probably Cecum
DUE TO
(B) Gastro intestinal Hemorrhage
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 2, 1949, to Aug. 8, 1949, that I last saw the deceased alive on 8/9, 1949, and that death occurred at 11:55 P. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas W. Mary M. D.	Mercy Hosp.	8/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 12 1949	Holy Redeemer Cem.	4430 Belair Rd. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Huntington Williams, M.D.	Frank Della Rocca	322 S. High St.

VS 150

46E

G7715.06

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G7715.06

1. NAME OF DECEASED (Type or Print): Frank Sulpizio

2. DATE OF DEATH: 8-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 417 Croydon Rd. 27-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	Aug. 5th 1897	52		4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clothing Desig.	Clothing Factory	Bucchianico Italy	U.S.

13. FATHER'S NAME: Celso Sulpizio

14. MOTHER'S MAIDEN NAME: Maria Di Carlo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Josephine Sulpizio ADDRESS: 417 Croydon Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Occlusion — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary Infarctions

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 26th, 1949, *to* Aug. 9th, 1949, *that I last saw the deceased alive on* Aug 9th, 1949, *and that death occurred at* 4:00 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Katharine V. Kemp M. D.	West Balto. Gen. Hosp.	Aug 9th 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 13/49	Holy Redeemer Cem.	4430 Belair Rd. Balt. Md.

DATE RECEIVED BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Huntington Williams, M.D.	Frank Della Rocca	322 S. High St.

VS 150

94a

GM. 130782 G77107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. B.C. 48-01073 — Registered No. G77107

1. NAME OF DECEASED (Type or Print): Ursula Patricia Powell

2. DATE OF DEATH: 8- 7- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2808 Simpson ST. Z 18 — 9-04

5. SEX: F
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: Jan. 4- 1948
9. AGE (In years last birthday): 19 Months (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard Lennox
14. MOTHER'S MAIDEN NAME: Rose Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records Balto. City Hospital — ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculosis Meningitis
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8- 3- , 1949, *to* 8- 7- , 1949, *that I last saw the deceased alive on* 8- 7- 1949, *and that death occurred at* 12.30 Am, *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 8-7- 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 10 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): A A County Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 10 1949
REGISTRAR'S SIGNATURE: [signature] M.D.
25. FUNERAL DIRECTOR: Mrs. Robert A. Elliott & Co.
ADDRESS: 13B 1129 N. Carlton St

VS 150

77108

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420 1 G77108

Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM D. HAEFFNER

2. DATE OF DEATH: August 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 5910 Marluth Road 26-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Jan. 3-1903	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maintenance	Gas & Electric	Baltimore Md	

13. FATHER'S NAME: Joseph Haeffner

14. MOTHER'S MAIDEN NAME: Sophia Schneider

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-03-9902

17. INFORMANT: Mrs. Clare E. Haeffner ADDRESS: 5910 Marluth

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — (INTERVAL BETWEEN ONSET AND DEATH)

DUE TO

(B) Arterio-sclerotic C. V. Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: August 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/12/49	Holy Redeemer	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 10 1949

REGISTRAR'S SIGNATURE: [signature] Funkhouser Williams, M.D.

25. FUNERAL DIRECTOR: Leonard J. Luck ADDRESS: 5305 Harford Rd

VS 151

77:09
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 77:09

1. NAME OF DECEASED (Type or Print) ELIZABETH G. BONNER

2. DATE OF DEATH August 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Mercy Hospital
c. Length of stay in Baltimore Two Weeks (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New York
B. COUNTY
c. CITY OR TOWN New York
D. STREET ADDRESS (If rural, give location) 1168 E. 18th. St.,

5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH May,3,1892
9. AGE (In years last birthday) 57 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse
10B. KIND OF BUSINESS OR INDUSTRY In Homes
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William A. Goodrich
14. MOTHER'S MAIDEN NAME Arrietta Burger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT ADDRESS Mrs.E.Curtiss,47BarrowSt.Ny. N. Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery disease
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Carl L. Rogers M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED August 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24B. DATE 8/10/49
24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery, Baltimore, Md.
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR AUG 10 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR C. V. Lemmon
ADDRESS 4611 Park Heights Ave.

VS 151

94a

7110

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

174 G77110 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BABY BOY SMOOT

2. DATE OF DEATH: Aug. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4811 Frederick Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 4811 Frederick Ave. 25-31

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	single	Aug. 10, 1949			15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Gardner Davis Smoot

14. MOTHER'S MAIDEN NAME: Leota Raab

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Mr. Gardner Davis Smoot ADDRESS: 4811 Frederick Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity (4½ to 5 mos)
DUE TO
(B) Premature separation of Placenta - 5 mos
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 15 min

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 8 10 1949 3.15 a. m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 10, 1949 *to* Aug 10, 1949, *that I last saw the deceased alive on* 8/10, 1949 *and that death occurred at* 3:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: J M Collins M. D.
23B. ADDRESS: 3321 Fredrick Ave
23C. DATE SIGNED: 8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/10/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

159

17111

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3560

Registered No. 17111

1. NAME OF DECEASED (Type or Print): ANNE ELIZABETH PAULUS

2. DATE OF DEATH: Aug. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2500 W. Lanvale St.
C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2500 W. Lanvale St. 16-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	Nov. 18, 1875	73 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore	

13. FATHER'S NAME: Charles H. Nelson

14. MOTHER'S MAIDEN NAME: Helen L. Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		none	Mrs. Helen Welsh	2104 Sunbriar Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Progressive muscular atrophy — INTERVAL BETWEEN ONSET AND DEATH: several yr.

DUE TO

(B) Paralysis of respiratory muscles

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-2-49, 19__, *to* 8-9-49 19__, *that I last saw the deceased alive on* 8-9-49 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	M. D.	23B. ADDRESS	23C. DATE SIGNED
Harry S. Grubbs		2203 Edmondson	8-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City or county) (State)
Burial	8/12/49	Woodlawn Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

82 29

77112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 G77112 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lydia Blaxton

2. DATE OF DEATH: 8/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 929 Wilmer Ct

c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 929 Wilmer Ct 17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	WIDOWED	? ? 1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LAUNDRESS	PRIVATE	BALTIMORE, MD.	

13. FATHER'S NAME: Jas. BAYERD

14. MOTHER'S MAIDEN NAME: SALLIE LARAY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		VIOLA COMMANDER	929 WILMER CT.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive C. V. Disease
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
P. C. Talbert M.D.		8/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-10-49.	MT. CALVARY	A. A. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Huntington Williams, M.D.	Wm. A. Jackson	916 Penna. Ave

(93)

77113.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59 G77113 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margreth B.Evans

2. DATE OF DEATH Aug.9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ashburton Nursing Home
c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
2048 Orleans St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md.
D. STREET ADDRESS (If rural, give location) 2048 Orleans St. 6-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Feb.24,1873	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---
10B. KIND OF BUSINESS OR INDUSTRY ----
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Thomas Daily
14. MOTHER'S MAIDEN NAME Mary ----
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ---
(If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. ---
17. INFORMANT ADDRESS Mr.Wm.A.Evans,125 N.Ellwood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremic Bronco Pneumonia Brasnus Comm
DUE TO Arteria Sclerosis Hypertension

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO Chronic Interstitial Nephritis
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
2 days
3 d
4 mo
4 mo
4 mo
4 mo

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 9, 19 49 *to* Aug 9, 19 49 *that I last saw the deceased alive on* Aug 8, 1949, *and that death occurred at* 8 am m., *from the causes and on the date stated above.*

23A. SIGNATURE S Pa Stevens M. D.
23B. ADDRESS 878 Harford Ky
23C. DATE SIGNED 8-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE July 12/49
24C. NAME OF CEMETERY OR CREMATORY Meadowridge Mem.Park
24D. LOCATION (City, town, or county) (State) Elkridge Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 10 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Philip Henry Sons,
ADDRESS 2024 Orleans St

VS 150

131a

7114

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77114

1. NAME OF DECEASED (Type or Print): ELLA RISON

2. DATE OF DEATH: Aug 10 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 27 N. Carey St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Home
c. Length of stay in Baltimore: Yrs. 1 Mos. month Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Indian Head
B. COUNTY: Charles Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Indian Head
D. STREET ADDRESS (If rural, give location): —

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Single	Unknown 1867	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker	Retired	Charles Co Md	

13. FATHER'S NAME: Robert Lee Rison

14. MOTHER'S MAIDEN NAME: Mary Maddox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Jessie Coates ADDRESS: 2626 Edgewood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Marked arteriosclerotic and hypertensive cardio-vascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Senile dementia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 15 July, 1949, *to* 10 Aug, 1949, *that I last saw the deceased alive on* 10 Aug, 1949, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Emil H. Henning Jr M. D.	4580 Edmondson Ave Balto 29	10 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 12 49	Congressional	Washington D C

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Huntington Williams, M.D.	W W Chambers Co.	517 11th St S.E.

VS 150

93D

77115
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77315
Registered No.

1. NAME OF DECEASED (Type or Print): Jane West

2. DATE OF DEATH: 8 Aug. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital (DOA)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1603 Ellsworth St

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 8/15/1879
9. AGE (In years last birthday): 69 70
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U-S
13. FATHER'S NAME: Archie Holmes
14. MOTHER'S MAIDEN NAME: Mary Clark
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Lillie Watson
ADDRESS: 1603 Ellsworth St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Nephritis
DUE TO
(B) Arteriosclerotic Cardio-Vascular Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2yrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Wm. H. Kammer Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 8 Aug. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/11/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): A.A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Rayner Sanders
ADDRESS: 1312 1412 E. Preston St

VS 151

77116

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 970.7 N-974.0

G77116

Registered No.

1. NAME OF DECEASED (Type or Print) FLOYD---THORTON FLOYD FRANK THORNTON

2. DATE OF DEATH August 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp. D.O.A.

c. Length of stay in Baltimore 2yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 3213 Cliftmont Avenue 8 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	Feb. 2, 1893	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer		Michigan	USA

13. FATHER'S NAME: James Thornton

14. MOTHER'S MAIDEN NAME: Jeanette Hamilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
yes	WW2	278-10-7842

17. INFORMANT ADDRESS: Mrs. Louise A. Thornton 3213 Cliftmont Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Seconal poisoning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3213 Cliftmont Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 8, 1949 ? a. m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Ingestion of sleeping tablets(seconal)

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE Earl L. Bryan M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED August 8, 1949

24A. BURIAL, CREMATION, REMOVAL cremation

24B. DATE 8/11/49

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State) Rochester, Michigan

DATE RECEIVED BY LOCAL REGISTRAR AUG 10 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.

BALTIMORE - 13, MD. 1630

VS 151

G77117 ✓ X G77117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

151 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Albert Selman

2. DATE OF DEATH August 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Owings Mills
D. STREET ADDRESS (If rural, give location) Academy Lane

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	9-18-81	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob Selman

14. MOTHER'S MAIDEN NAME Louise Whitman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular accident - post operative. — INTERVAL BETWEEN ONSET AND DEATH: 1d

DUE TO

(B) Essential hypertension associated with. — —

(C) Inoperable Cancer of Stomach

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic heart disease

19A. DATE OF OPERATION Aug 2, 1949. — 19B. MAJOR FINDINGS OF OPERATION Inoperable Cancer of Stomach — 20. AUTOPSY? YES ☐ NO ☒ A

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-31, 1949 *to* 8-9, 1949 *that I last saw the deceased alive on* 8-9, 1949 *and that death occurred at* 540 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE Duane L. Merrill M. D. — 23B. ADDRESS JOHNS HOPKINS HOSPITAL — 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 12-49	Rustretown Methodist	Rustretown Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 10 1949 — REGISTRAR'S SIGNATURE Washington Williams, M.D. — 25. FUNERAL DIRECTOR J F Cline Sons — ADDRESS Rustretown

VS 150

46B

G77118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77118

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Etta Cabell

2. DATE OF DEATH: AUG 10 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2639 Guilford Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	10-10-92	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Humphreys
14. MOTHER'S MAIDEN NAME: Margaret Taylor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intertrochanteric fracture right hip. Due to (B) — INTERVAL BETWEEN ONSET AND DEATH: 7-21-49 to 8-10-49

DUE TO (B) Multiple myeloma — 4 years

DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
William J. McClafferty M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2639 Guilford Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: 7-21-49
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Fell while walking

22. *I hereby certify that I attended the deceased from* 7-21 1949 to 8-10 1949, *that I last saw the deceased alive on* 8-10 1949, *and that death occurred at* 1.05 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert S. Wilson M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 12 1949
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Waynesboro Va
DATA RECEIVED BY REGISTRAR: AUG 10 1949
REGISTERED (DATE): Aug 10 1949
25. FUNERAL DIRECTOR: Henry H. Thomas ADDRESS: 1424 Edgewood St

Medical Ex. Case To be approved 55E.

Medical Examiner's Release

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E900.0

G77119

Registered No.

BIRTH NO. G77119

Pro. J

1. NAME OF DECEASED (Type or Print): Mary E. W. Spielman

2. DATE OF DEATH: August 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 554 E. 38th Street 9 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Fe.	White	Married	July 4, 1865	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hwfe.		Virginia	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Simple transverse fracture of neck of left femur.

DUE TO

(C)

CERTIFICATION APPROVED BY

William J. McCafferty M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Home	554 E. 38th Street 9 01

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 11, 1949 ? m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Slipped and fell down stairs (inside home)

22. *I hereby certify that I attended the deceased from* 7/25/49, 19__, *to* 8/9/49, 1949, *that I last saw the deceased alive on* 8/9/49, 1949, *and that death occurred at* 7:15 AM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Howard Johnson M. D.	1400 N. Caroline Stteet	8/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	8/11/49	Downing	Oak Hill Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Huntington Williams, M.D.	William Cox Inc	127 E. 22nd St

VS 150

186a

G77120 V-491 G77120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNIE MARGARET KNAUER

2. DATE OF DEATH: Aug. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Haven Nursing Home, 4515 Garrison Blvd.
C. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2715 Tivoly Ave. 9-06

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: May 27, 1855
9. AGE (In years last birthday): 94
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME: Leonard Roesel
14. MOTHER'S MAIDEN NAME: Helena Eckstein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Helena Gleisner
ADDRESS: 5507 Elsrode Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

II
(C)
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 7 Days

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 5 1949 *to* Aug. 9 1949 *that I last saw the deceased alive on* Aug. 5 1949, *and that death occurred at* 12:05 P.m. *from the causes and on the date stated above.*

23A. SIGNATURE M.D. William F. Kostein
23B. ADDRESS 11 E. Chase St.
23C. DATE SIGNED 8-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/11/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 10 1949
REGISTRAR SIGNATURE: Jos. Williams, M.D.
25. FUNERAL DIRECTOR: William Cook, Inc
ADDRESS: 1217 St. Paul St.

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G77121 CERTIFICATE CORRECTED 8-18-49 E8 G77121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C.F-8789 Registered No.

1. NAME OF DECEASED (Type or Print) CHRISTINE FINCHER (CLIFTEEN) N-804.r

2. DATE OF DEATH August 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1022 W. Franklin St. 18-0 r

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	S	10-15-1943	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child	—	Balto. Md	U.S.A.

13. FATHER'S NAME Robert Fincher

14. MOTHER'S MAIDEN NAME Lydia Wallace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Stella Wallace	1022 W. Franklin

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (B) Intracranial hemorrhage. Fractured right leg.

DUE TO (C) Atelectasis of lungs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	public	Street, Franklin Street 50' north of 18/2

21D. TIME OF INJURY (Month) (Day) (Year)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 8, 1949 Approx. 4 P. m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Ped. struck by auto.

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
George G. Merrill M.D.		August 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/11/49	Mt Auburn	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Tuntington Williams, M.D.	Geo. C. Kelson	1303 Pressman St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67322

BIRTH NO. 67322

1. NAME OF DECEASED (Type or Print) THOMAS F GEORGE

2. DATE OF DEATH Aug 9. 1949

3. PLACE OF DEATH:
A. Baltimore City. Maryland 305 Fonthill Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 305 Fonthill Ave
C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 305 Fonthill Ave 20-06

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov 9. 1887
9. AGE (In years last birthday) 61 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary fireman
10B. KIND OF BUSINESS OR INDUSTRY Coke oven Work
11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frederick George
14. MOTHER'S MAIDEN NAME Mary R. Lautner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 215-09-9056
17. INFORMANT Mary A. George ADDRESS 305 Fonthill Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.

DUE TO

(B) myocardial insufficiency ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947 to Aug 9, 1949 that I last saw the deceased alive on Aug 9, 1949, and that death occurred at 10 30 a. m., from the causes and on the date stated above.

23A. SIGNATURE John Williamson M. D.
23B. ADDRESS 3325 Frederick Rd
23C. DATE SIGNED 8/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/12/49
24C. NAME OF CEMETERY OR CREMATORY Woodlawn
24D. LOCATION (City, town, or county) (State) Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 10 1949
REGISTRAR'S SIGNATURE Acting for John Williamson, M.D.
25. FUNERAL DIRECTOR John J. Cowan & Son ADDRESS 901 Hollins St.

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G77123 G77123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) [redacted] CARMELO AVARA

2. DATE OF DEATH Aug 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2364 Wilkens Ave.
c. Length of stay in Baltimore 32 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2364 Wilkens 20-05

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 23, 1905
9. AGE (In years last birthday) 46 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Simon Avara
14. MOTHER'S MAIDEN NAME Carmella Bianea
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) None (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT Concetta Avara, ADDRESS 2364 Wilkens Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculosis, pulmonary — INTERVAL BETWEEN ONSET AND DEATH 1 yr 5 mos
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from 3-22-49 to 8-7-49 that I last saw the deceased alive on 8-6-49 and that death occurred at 1:15 p m., from the causes and on the date stated above.

23A. SIGNATURE John P. Urlock, Jr. M. D.
23B. ADDRESS 1227 Washington Blvd
23C. DATE SIGNED 8-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8-10-49
24C. NAME OF CEMETERY OR CREMATORY New Cathedral
24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR AUG 10 1949
REGISTRAR'S SIGNATURE Kenneth Williams, M.D.
25. FUNERAL DIRECTOR Fred A. Dole
ADDRESS 1918 W. Balto. St.

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G77124 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77124

1. NAME OF DECEASED (Type or Print): JOHN J. BROWN — 2. DATE OF DEATH: August 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): (d.o.a.) South Balto. Gen. Hospital
C. Length of stay in Baltimore: 35 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 808 Ostend Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Feb. 18. 1901	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Trackman	B & O R.R.	Huston Texas	U.S.A.

13. FATHER'S NAME: Gile Brown
14. MOTHER'S MAIDEN NAME: Myrah Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Annie Brown	808 Oston St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fractured skull
DUE TO
(B) Intracranial hemorrhage
DUE TO
(C) Contusion of brain.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	B.& O. Prop.	In rear of Md. Glass Co., 2147 Wicomico Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21F. HOW DID INJURY OCCUR?
Approx. August 7, 1949 6:45 p.m.		Ped. struck by train

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER [X] / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George L. Merrill M.D.		August 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 11. 1949	Mt Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Hunter for Williams, M.D.	Elroy O. Wilson	1000 Brantly Ave.

VS 151

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G77125

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 983.0

G77125

Registered No.

1-991

1. NAME OF DECEASED (Type or Print) EFFIA K. KEFALOS

2. DATE OF DEATH August 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital (d.o.a.)

C. Length of stay in Baltimore — Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 2049 Fleet Street 2-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	widowed	about 1894	55 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Fairmont, W. Va.	

13. FATHER'S NAME: John Rogers

14. MOTHER'S MAIDEN NAME: Sarah Cole

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Jones Funeral Home	Fairmont, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Strangulation

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS - CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	2049 Fleet Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 8, 1949 ? m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Strangled with electric ironing cord

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X] undetermined [ ].*

Autopsy, Inspection or Inquiry

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
George G. Merrill M.D.		August 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	8/10/49		Fairmont, W. Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

168

B.C.49-16514

G77126

BIRTH NO. Du Cranthus

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 77 0 G77126 Registered No.

1. NAME OF DECEASED (Type or Print): Barbara Ann Easter

2. DATE OF DEATH: 8-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2025 W. Fayette St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

C. Length of stay in Baltimore: 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore - 29,
D. STREET ADDRESS (If rural, give location): 520 Random Road 25-31

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F,	W.	Single	8-8-49			1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Joseph Easter

14. MOTHER'S MAIDEN NAME: Dorothy May Patterson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ERYTHROBLASTOSIS FOETALIS

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 8, 1949, *to* Aug 10, 1949 *that I last saw the deceased alive on* Aug. 9, 1949, *and that death occurred at* 2:50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul D. Manning M. D.

23B. ADDRESS: Bon Secours Hospital

23C. DATE SIGNED: 8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-11-49	Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 10 1949

REGISTRAR'S SIGNATURE: Hunter Town Williams, M.D.

25. FUNERAL DIRECTOR: George A. Farley ADDRESS: Fulton Ave & Fayette St.

161c

G77127 ✓ 10.1 G77127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HERMAN Link

2. DATE OF DEATH Aug. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City. Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 407 S. Bentalou St.

c. Length of stay in Baltimore 68 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 20-5
D. STREET ADDRESS (If rural, give location) 407 S. Bentalou St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	White	MARRIED	MAY 15, 1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Butcher	Meat	GERMANY	U.S.A.

13. FATHER'S NAME August Link

14. MOTHER'S MAIDEN NAME Marie Sadusky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	NONE	216-01-7169A	August Link	407 S. Bentalou St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of Bladder	
DUE TO	(B) Coronary occlusion	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	(C) none	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/2, 19 49 *to* 8/9, 19 49, *that I last saw the deceased alive on* 8/9, 19 49 *and that death occurred at* 1:40 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Wilkes MD M. D.	2030 Wilkens Ave	8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-12-49	WESTERN Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
10 1949	Washington Williams, M.D.	Geo. L. Schwab	2101 Frederick Ave.

VS 150

52B

Malinda

BIRTH NO G77128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E9 G77128 Registered No.

1. NAME OF DECEASED (Type or Print) MALINDA BUHNER N-810.0

2. DATE OF DEATH August 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Millers
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White		Oct-18/1869	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or Foreign Country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Baltimore Co. Md.	

13. FATHER'S NAME John Ellis

14. MOTHER'S MAIDEN NAME Mary Anne Robotham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia

DUE TO

(B) Fracture, right clavicle

DUE TO Multiple Contusions

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home of Mrs. W.H. Cambrill

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Freeland, Balto. Co., Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 3, 1949 10 a.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Found lying on the ground below the second story window (12')

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE William J. McCafferty M.D. (probable)

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED August 10, '49

24A. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify)	24B. DATE	24C. NAME of CEMETERY or ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
	Aug 13 1949	Middletown	Freeland Md.

DATE RECEIVED BY REGISTRAR AUG 10 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR J. Jacob Harlenstein ADDRESS 18 a New Freedom, Penna.

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BIRTH NO. G77129

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

330 Registered No. G77129

1. NAME OF DECEASED (Type or Print): Annie Hicks Harris

2. DATE OF DEATH: 8-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp.

C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 16-3
D. STREET ADDRESS (If rural, give location): 1124 N. Gilmore st

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	C		10/20/04	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework.		Centreville Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James James	Malinda Sidler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Edna Robinson	Stevensville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage — Interval between onset and death: Undet.

DUE TO

(B) Hypertension — Undet.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-9-1949 to 8-10-1949 that I last saw the deceased alive on 8-10, 1949 and that death occurred at 6:25 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S.E. Brady per L.W. Sawyer M.D.	President Hospital	8-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	aug 13-49	Stevensville md	Stevensville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Tuntington Williams, MD	Lewis A. Henry	Centreville Md.

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AUG 10 1949

830

G77130

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77130

Registered No.

1. NAME OF DECEASED (Type or Print): Amos Davis

2. DATE OF DEATH: Aug. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 719 Reservoir St.

c. Length of stay in Baltimore: 1 Yrs. Mths. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 719 Reservoir St., 12-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Widowed	5-18-1862	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Maryland	U.S.A.

13. FATHER'S NAME: Frank Davis

14. MOTHER'S MAIDEN NAME: Anna Hammond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		none	Mrs. Everett Stevens	719 Reservoir St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24± hrs.
DUE TO
(B) Arteriosclerosis, cerebral — 4 years -
DUE TO
(C) Arteriosclerosis, general

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7 Aug, 1949 *to* 8 Aug, 1949 *that I last saw the deceased alive on* 8 Aug, 1949, *and that death occurred at* 9:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Hamburger Jr. M. D.	1207 Eutaw St.	9 Aug 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-11-1949	Church Of God	Winfield, Carroll Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 11 1949	Huntington Williams, M.D.	C. M. Waltz	Winfield, Md.

VS 150

83a

G77131 G77130

95° G77131

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SHIRLEY WARD

2. DATE OF DEATH: AUGUST 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SYDENHAM HOSPITAL
C. Length of stay in Baltimore: Yrs. 5 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: ALLEGHANY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KEYSER, W. Va
D. STREET ADDRESS (If rural, give location): RFD #3 Box 89

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: JUNE 11, 1948
9. AGE (In years last birthday): 1
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): KEYSER, W. Va
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE WARD
14. MOTHER'S MAIDEN NAME: MARY WARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: FATHER
ADDRESS: SEE ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio respiratory failure
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5 days

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* AUGUST 6, 1949 *to* AUGUST 10, 1949 *that I last saw the deceased alive on* AUGUST 10, 1949, *and that death occurred at* 1:35 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Solomon G Young M. D.
23B. ADDRESS: Lyden Hospital
23C. DATE SIGNED: Aug 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/11/49
24C. NAME OF CEMETERY OR CREMATORY: Dawson
24D. LOCATION (City, town, or co.) (State): Dawson Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilson & Son
ADDRESS: 1217 Druid St

VS 150

200a

G77132

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3, 3 ✓

G77132

Registered No.

1. NAME OF DECEASED (Type or Print) Anna M. Foley

2. DATE OF DEATH 8/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Avon Apts.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6 East Read St.

c. Length of stay in Baltimore — Yrs. Life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY ---

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 6 East Read St. 11-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Female	White	Single	---	76	--	--	--	-

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	------	Baltimore, Md.	--------

13. FATHER'S NAME: Matthew J. Foley

14. MOTHER'S MAIDEN NAME: Mary Isabella Roper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	----------	---------

17. INFORMANT: Mrs. Jeannette Yelverton — ADDRESS: 6 East Read St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Thrombosis, Left Middle Cerebral Artery — DUE TO

(B) Arteriosclerosis, advanced — DUE TO

(C) ---

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/13, 1949, to 8/9, 1949, *that I last saw the deceased alive on* 8/6, 1949, *and that death occurred at* 1:15 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	11 E. Chase St.	8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/12/49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 11 1949	Huntington Williams, M.D.	H. H. Mears & Son	805 N. Calvert St.

VS 150

83B

G77133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 7 5 4

Registered No. G77133

BIRTH NO. B.C. 48-09062

1. NAME OF DECEASED (Type or Print): Albert P. Reeb

2. DATE OF DEATH: August 10th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital.

C. Length of stay in Baltimore: 15 months. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 19-4
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 1808 Dover St., Balto. 23, Md.

5. SEX: M

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S.

8. DATE OF BIRTH: 4-16-48.

9. AGE (In years last birthday): If Under 1 Year: Months 15 Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Mr. George W. Reeb.

14. MOTHER'S MAIDEN NAME: Eileen Cavanaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Geo. W. Reeb — ADDRESS: 1808 Dover St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Upper Respiratory

DUE TO Infection.

(B) Mongolism.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 11th, 1949, to August 10th, 1949, *that I last saw the deceased alive on* August 10th, 1949, *and that death occurred at* 8 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. J. Castellano M. D.

23B. ADDRESS: Bon Secours Hospital

23C. DATE SIGNED: August 10th 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Aug 13/49

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Harry A. Witzke — ADDRESS: 401 Edmondson Ave

1042

VS 150

G77134

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77134

Registered No.

1. NAME OF DECEASED (Type or Print) **Harry R. Meek**

2. DATE OF DEATH **Aug. 9/49**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **Balto. Md.**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **400 Edgewood St.**
c. Length of stay in Baltimore **Life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **400 Edgewood St.** 21-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	**W.**	**Single**	**July 13,1884**	**65**		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	**Western Md. R.R.**	**Maryland**	

13. FATHER'S NAME **Alexander Meek**

14. MOTHER'S MAIDEN NAME **Eliza Bradley**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT **Sister** ADDRESS **Mrs. Agnes Harriman, 400 Edgewood St**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) **Chronic Myocarditis** — INTERVAL BETWEEN ONSET AND DEATH **1 Year**
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **Aug 10** *, 19* **49** *to* **Aug 9** *19* **49** *that I last saw the deceased alive on* **Aug 9** *, 19* **49** *, and that death occurred at* **9 P** *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. A. Lally M. D.	**3517 Edmondson Ave**	**Aug 10 1949**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**Aug. 12/49**	**Lorraine Park**	**Woodlawn, Md.**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 11 1949	**Thurlington Williams, M.D.**	**Harry A. Winters**	**3101 Edmondson Ave.**

VS 150

937

77135 BALTIMORE CITY HEALTH DEPARTMENT 776 G77135

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Daley "Boy" Ruark

2. DATE OF DEATH AUG - 1 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Pasadena
D. STREET ADDRESS (If rural, give location) Cath ave

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 7.31.49 | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days 1 | If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Ruark.

14. MOTHER'S MAIDEN NAME Frances

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT | ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity —
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7.31 1949 to 8-1 1949, *that I last saw the deceased alive on* 8-1 1949, *and that death occurred at* 5:30 a m., *from the causes and on the date stated above.*

23A. SIGNATURE William W Waring M. D. | 23B. ADDRESS JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR AUG 1 1 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR | ADDRESS

VS 150

Hospital Disposal

159

G77136

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

450.0 G77136

Registered No.

1. NAME OF DECEASED (Type or Print): Debbie Spruill

2. DATE OF DEATH: 8/9/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1611 N. Caroline St

B. FULL NAME OF HOSPITAL OR INSTITUTION: (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: XXXXX Md. B. COUNTY:
c. CITY OR TOWN: (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location): 1611 N. Caroline St. 8-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (If over 1 year, last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	W Ernest	10/15/1875	73 74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N. Carolina
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry Howard
14. MOTHER'S MAIDEN NAME: Mahalie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Nathaniel Johnson — ADDRESS: 6524 Luzon Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO
(B) Hemiplegia — 1 wk.
DUE TO
(C) Vascular Sclerosis Indefinite

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-7 3:30 p 19 49 to 8-9 19 49, that I last saw the deceased alive on 8-9 19 49, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE: Jas. R. Blake M. D.
23B. ADDRESS
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/11/49
24C. NAME OF CEMETERY OR CREMATORY: Washington D. C.
24D. LOCATION (City, town, or county) (State): Washington D. C.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Geo. C. Kelson 1303 Presstman St.

VS 150

918

77137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E98r. 0

Registered No. 77137

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward A. Thomas N-861.

2. DATE OF DEATH: Agust 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. Gen. Hosp.
C. Length of stay in Baltimore (Yrs. Mos. Days): All Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 21-1
D. STREET ADDRESS (If rural, give location): 619 W. Montgomery St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Male	Colored	Married	July 20, 1924	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Helper On Truck	Balto. City	Baltimore Md.	U.S.A.

13. FATHER'S NAME: Edward Thomas

14. MOTHER'S MAIDEN NAME: Ruth Carey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service) Ware # 2

16. SOCIAL SECURITY NO.

17. INFORMANT: Audrey Thomas ADDRESS: 426 W. Hamburg St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Stab-wound of aorta
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 619 W. Montgomery Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): August 7, 1949 approx. 6:40 p. m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Sharp instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: George S. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: August 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 11. 49	Balto. Nat. Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Elron O. Wilson ADDRESS: 1000 Brantly Ave.

VS 151

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G77138 — BALTIMORE CITY HEALTH DEPARTMENT — 17 — G77138

BIRTH NO. — CERTIFICATE OF DEATH — Registered No.

1. NAME OF DECEASED (Type or Print): FANNIE SCHREIBMAN

2. DATE OF DEATH: 8-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1122 Proctor St
C. Length of stay in Baltimore: 26 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1122 Proctor St 10-1

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 47 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Goda Kaib
14. MOTHER'S MAIDEN NAME: Lipper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Benjamin Schreibman — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO
(B) cerebral metastases
DUE TO
(C) Carcinoma of the breast with metastases — 2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-23-1949 to 8-10-, 1949 that I last saw the deceased alive on 8-10-, 1949, and that death occurred at 2 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Bernard Burgin M. D. M. D.
23B. ADDRESS: 6721 Reisterstown Rd.
23C. DATE SIGNED: 8/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-11-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

50

77139

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61°

Registered No. 077139

1. NAME OF DECEASED (Type or Print): LEVIN, Jacob

2. DATE OF DEATH: 10 Aug 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: 56 Yrs. ~~Mos.~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Levindale 27-17

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday) / If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.: 78

10A. USUAL OCCUPATION (Give kind of work done during greater part of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Jennie Levin ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Insufficiency
DUE TO
(B) Hemorrhage
DUE TO
(C) Prostatectomy

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 9 Hrs

19A. DATE OF OPERATION: 5 July 1949
19B. MAJOR FINDINGS OF OPERATION: Benign Prostatic Hypertrophy
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): N
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): N
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): N
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): N m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? N

22. *I hereby certify that I attended the deceased from* 5 July, 1949, *to* 10 Aug, 1949, *that I last saw the deceased alive on* 10 Aug, 1949, *and that death occurred at* 8:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis Feberlin M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 10 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-11-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

137a

77140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47 0-1

Registered No. G77140

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Martha Ross Darby

2. DATE OF DEATH Aug 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1708 Eutaw Place

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmhurst Nursing Home

c. Length of stay in Baltimore 1 Yr (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 14-3
D. STREET ADDRESS (If rural, give location) 1900 EUTAW PL.

5. SEX Fe | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH June 5, 1858

9. AGE (In years last birthday) 91 | If Under 1 Year: Months 2, Days 3 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Oak Grove, Dela

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Perry T. Darby

14. MOTHER'S MAIDEN NAME Lillian OsBier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Harry E Darby ADDRESS 1900 Eutaw Pl

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO Senile arterio - sclerosis

(B) Senility — Long

DUE TO

(C) Uterine carcinoma-(Possible) — 2 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 1944, 19__, *to* August 8 19 49 *that I last saw the deceased alive on* 8/5/49, 19__ *and that death occurred at* 7:30 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE M. D. | 23B. ADDRESS 1901 Eutaw Place, City | 23C. DATE SIGNED 8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug 12, 1949 | 24C. NAME OF CEMETERY OR CREMATORY St Lukes Cemty | 24D. LOCATION (City, town, or county) (State) Seaford, Delaware

DATE RECEIVED BY LOCAL REGISTRAR AUG 11 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Harry E. Darby ADDRESS 1900 Eutaw Pl

VS 150

94a

77141 ✓ x 540.1 G77141

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Katie Brown

2. DATE OF DEATH 8/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home And Hospital

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Essex
D. STREET ADDRESS (If rural, give location) Box 60. Route 13 - Islandview Rd.

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 9/11/1881 | 9. AGE (In years last birthday) 67 | If Under 1 Year: Months 10, Days 20 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME John Reirhest

14. MOTHER'S MAIDEN NAME Rosina Hahn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Betty Lou Markee ADDRESS C.H. & Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Perforation of Carcinoma of Stomach
DUE TO Peritonitis due to acute perforation — Interval between onset and death: 1 wk.

(B)
DUE TO

(C) Hypertension & Myocardial Degeneration — 11 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 7, 1949, to Aug. 10, 1949 *that I last saw the deceased alive on* Aug 10, 1949, *and that death occurred at* 8:55 A m., *from the causes and on the date stated above.*

23A. SIGNATURE J. A. Means, M.D. M. D. | 23B. ADDRESS Church Home & Hospital | 23C. DATE SIGNED 8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug. 13, 1949 | 24C. NAME OF CEMETERY OR CREMATORY Parkwood | 24D. LOCATION (City, town, or county) (State) Balto, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 11 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Lazarus Funeral Home | ADDRESS 7401 Belair Rd.

VS 150

117a

BIRTH NO. 7142 JL 127861

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

33 ✓ Registered No. G77142

1. NAME OF DECEASED (Type or Print): Anna Pessagno

2. DATE OF DEATH: 8-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-7
D. STREET ADDRESS (If rural, give location): 1913 E. Hoffman ST.

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Wid.
8. DATE OF BIRTH: Dec. 25 1879
9. AGE (In years last birthday): 69 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Mitchell
14. MOTHER'S MAIDEN NAME: Sarah Ewing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: B. C. H. Records ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Bronchopneumonia
Diabetis Mellitus

CERTIFICATION APPROVED BY
W. H. Merrill M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar. 28- , 1949 , *to* Aug. 9- , 19 49 *that I last saw the deceased alive on* Aug. 9- 1949 , *and that death occurred at* 11.30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: G. S. Cogen M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 8- 10 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/12/49.
24C. NAME OF CEMETERY OR CREMATORY: Moulond Pk
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holmond & Dod ADDRESS: 1217 E Fond St

VS 150

To Be Approved By The Chief Medical Examiner. 61

77143

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

G77143

Registered No.

1. NAME OF DECEASED (Type or Print): ELIZABETH O'ROURKE

2. DATE OF DEATH: AUG. 8 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5614 BENTON Hgts. Ave.

c. Length of stay in Baltimore: LIFE (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 5614 BENTON Hgts AVE - MD
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO. 27-34
D. STREET ADDRESS (If rural, give location) 5614 BENTON Hgts AVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	W	JUNE 19, 1877	72 YRS.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	at Home	BALTO - MD.	USA

13. FATHER'S NAME: Theodore J. Havelman

14. MOTHER'S MAIDEN NAME: Lasetta Summers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		LAZETTA MORAN. 901 HIGNETWAY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

DUE TO

(B) Hypertension, malignant — UNKNOWN

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive Cardio Vas Disease
Arteriosclerosis, generalized "

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 6 1949, to Aug. 8, 1949 *that I last saw the deceased alive on* Aug. 8 1949 *and that death occurred at* 9:15 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry J. Houska, M. D.	333 S. East Ave.	Aug 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	08-12-1949	New Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 11 1949	Huntington Williams, MD	Elmer W. Conklin	924 E. Eager St.

VS 150

93D

G77149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77149

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ida Fredriksen Hamburger

2. DATE OF DEATH: Aug. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 405 Gittings Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 405 Gittings Ave. 29-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Dec. 11, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Florida

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ole Hans Fredriksen

14. MOTHER'S MAIDEN NAME: Rosina Dunn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — ADDRESS: Alfred H. Burnham, 405 Gittings Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 min

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardiovasc. disease — 1 8 mo.

DUE TO c pneumonia infection

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Carcinoma of ovary, st — surgically treated — 1 yr

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8 Dec, 1949 *to* 9 Aug, 1949, *that I last saw the deceased alive on* 9 Aug, 1949, *and that death occurred at* 10:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Dud B Cope Jr M. D.

23B. ADDRESS: 2843 St Paul

23C. DATE SIGNED: 11 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 8/12/49

24C. NAME OF CEMETERY OR CREMATORY: Greenmount

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949

REGISTRAR'S SIGNATURE: Tuttington Williams, MD

25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc. 1217 St. Paul St.

VS 150

49a

G77145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

Registered No. G77145

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Julia R. Piquett

2. DATE OF DEATH Aug 10 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3318 Frederick Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3318 Frederick Ave 20-8

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Nov 21 1863	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country) Montgomery Co Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thomas Brown

14. MOTHER'S MAIDEN NAME Katherine Moxley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mary Irene Fitze ADDRESS 3318 Frederick Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema

DUE TO

(B) Hypertension

DUE TO

(C) Cardio Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1948 *to* Aug 10 1949 *that I last saw the deceased alive on* Aug 10 1949 *and that death occurred at* 11 a *m., from the causes and on the date stated above.*

23A. SIGNATURE Robert C. Ritchie M. D.

23B. ADDRESS 251 W Lexington St

23C. DATE SIGNED Aug 10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Aug 13 1949

24C. NAME OF CEMETERY OR CREMATORY Loudon Park

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 11 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR Harry J. Mumaw ADDRESS 2204 Ridgewood Ave

937

VS 150

G77146

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43

G77146

Registered No.

1. NAME OF DECEASED (Type or Print): Alvina C. Engnoth

2. DATE OF DEATH: Aug. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 100 N. Highland ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-10
D. STREET ADDRESS (If rural, give location): 100 N. Highland Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	Oct. 5, 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Germany	

13. FATHER'S NAME: Hoft

14. MOTHER'S MAIDEN NAME: Nitcher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Herman G. Engnoth 100 N. Highland Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular Renal — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/1 19 49 *to* 8/9 19 49 *that I last saw the deceased alive on* 8/9 19 49 *and that death occurred at* 3.45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles Thomas M. D.	3123 Eastern Ave	8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/13/49	Oak Lawn	7225 Eastern Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
AUG 11 1949	Huntington Williams, M.D.	Clarence F. Hoffmann 1639 Broadway.

VS 150

93D

G771-47

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-20-1 G771-47

Registered No.

1. NAME OF DECEASED (Type or Print): Katherine A. Day

2. DATE OF DEATH: Aug. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4515 Mannasota Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 26-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Divorced	Feb. 21, 1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore	

13. FATHER'S NAME: Charles Pabst

14. MOTHER'S MAIDEN NAME: Elizabeth Altevogt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Marie Seifert	4515 Mannasota Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Renal disease — Interval between onset and death: 1942

DUE TO

(B) Acute Coronary Thrombosis — May 2 1949

DUE TO

(C) Chr Glomerular Nephritis c renal failure — June 2 1949

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	None	None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
None m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	None

22. *I hereby certify that I attended the deceased from* May 1 1942 *to* Aug 9, 1949 *that I last saw the deceased alive on* Aug 8, 1949 *and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
F. A. Scheinuk M. D.	842 S. East Ave	8-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 13, 49	Mt. Carmel	5712 O'Donnell St.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 11 1949	Lexington Williams, M.D.	Clarence F. Hoffmann, 1639 Broadway

VS 150

131a

77148

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 77148

1. NAME OF DECEASED (Type or Print): Bertha L. Musch

2. DATE OF DEATH: Aug. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 913 S. Conkling St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 913 S. Conkling St. 26-9

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Aug. 29, 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Germany	

13. FATHER'S NAME: Henry Borleis

14. MOTHER'S MAIDEN NAME: Elizabeth Hildebrandt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Carl B. Musch 913 S. Conkling St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Myocardial Infarction	2 wks.
DUE TO		
(B)	Coronary Arteriosclerosis	?
DUE TO		
(C)	Generalized Arteriosclerosis	10 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct., 1946, *to* August, 1949, *that I last saw the deceased alive on* Aug 6, 1949, *and that death occurred at* 4:30 A. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Clarence W. LeGoux M. D.	2023 Eastern Ave.	8/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/11/49	Parkwood	Taylor Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
AUG 11 1949	Huntington Williams, M.D.	Clarence F. Hoffmann 1639 Broadway

VS 150

94a

G77149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

00 ✓ Registered No. G77149

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RUTH THOMAS

2. DATE OF DEATH 8-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

c. Length of stay in Baltimore LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 582 Oxford Street 17-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	SINGLE	11-27-1926	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
WAITRESS	RESTAURANT	BALTO. MARYLAND.	

13. FATHER'S NAME JAMES THOMAS

14. MOTHER'S MAIDEN NAME SALLIE HINES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		SALLIE FULLER - 592 OXFORD ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE George H. Merrill M.O.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED 8/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-12-49.	MT. AUBURN	BALTO. CO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, Md

25. FUNERAL DIRECTOR ADDRESS: Wm. A. JACKSON - 916 PENNA. AVE.

VS-151

120

G77150

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63 Registered No. G77150

1. NAME OF DECEASED (Type or Print): JOSEPH M. DOWNEY

2. DATE OF DEATH: 8-9-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3013 FAIT AVE.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3013 FAIT AVE.

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 4-24-1891
9. AGE (In years last birthday): 58 — If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER
10B. KIND OF BUSINESS OR INDUSTRY: AMER. SMELTING
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: PATRICK DOWNEY
14. MOTHER'S MAIDEN NAME: CATHERINE FLYNN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: ANNA V. DOWNEY — ADDRESS: 3013 FAIT Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Rt. Lung — Interval between onset and death: Nov 30/48
DUE TO
(B) None
DUE TO
(C) None

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
None

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): None
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: None
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? None

22. *I hereby certify that I attended the deceased from* Nov 30, 1948, *to* Aug 9, 1949, *that I last saw the deceased alive on* Aug 8, 1949, *and that death occurred at* 12:05 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 842 Eastern
23C. DATE SIGNED: 8-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 8-12-49.
24C. NAME OF CEMETERY OR CREMATORY: OAK LAWN CEM
24D. LOCATION (City, town, or county) (State): EASTERN AVE. MD

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949
REGISTRAR'S SIGNATURE: Temporary for Williams, MD
25. FUNERAL DIRECTOR: Charles L. Zeiler — ADDRESS: 901 S. Conkling St.

47D

G77151

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77151

1. NAME OF DECEASED (Type or Print): ANNA F. POETZEL

2. DATE OF DEATH: 8/10/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 805 S. EATON ST.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore ABOUT 60 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 26-9
D. STREET ADDRESS (If rural, give location): 805 S. EATON ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
FEMALE	WHITE	WIDOWED	APR. 23, 1874	75				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WORK	AT HOME	GERMANY	U. S. A.

13. FATHER'S NAME: GERARD KAPPAN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: FRANK G. POETZEL ADDRESS: 805 S. EATON

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C. V. Disease — INTERVAL BETWEEN ONSET AND DEATH: Dec 12/48

DUE TO

(B) Congestive Failure — May 2/49

DUE TO

(C) Ruptured Esophageal Varices — 8-8-49

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	None	None

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
None m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	None

22. *I hereby certify that I attended the deceased from* Dec 12, 1948 *to* June 10, 1949, *that I last saw the deceased alive on* 6-9-, 1949, *and that death occurred at* 8:25 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sidney Weinrich M. D.	842 S. Eaton St	8-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-13-49	SACRED HEART CEM	GERMAN HILL RD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 11 1949	Huntington Williams, M.D.	Charles L. Zirkin	901 S. Conkling St

VS 150

937

G77152 Combs ✓ 650.2 G77152

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Helen Coombs (Combs) — 2. DATE OF DEATH: 8/6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 204 Bethel
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 204 Bethel — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md
D. STREET ADDRESS (If rural, give location): 204 Bethel Ct 6-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	M	1/22/20	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. W. — 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Balto. Md — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Davis — 14. MOTHER'S MAIDEN NAME: Mamie Mason

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.

17. INFORMANT: Lomas Grant — ADDRESS: 204 Bethel St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chloroform anaesthesia Cesarean Section — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) criminal abortion - incomplete — 19 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Incomplete A. B.

over

19A. DATE OF OPERATION: 8/5 & 8/6 — 19B. MAJOR FINDINGS OF OPERATION: Retained Secundines — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/3 - 49 *to* 8/6 - 49, *that I last saw the deceased alive on* 8/6 - 49, *and that death occurred at* 8:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: B. W. Rhatty, M. D. — 23B. ADDRESS: 2135 W. Hall Ave — 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/12/49	St Peters	Md

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Geo. H. Kelson — ADDRESS: 1303 Pennsylvania Ave.

VS 150
AUG 11 1949

141F

JL - 130817

BIRTH NO. 49-16305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77153

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Jones - Debarco

2. DATE OF DEATH: Aug. 10, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Ave. Baltimore City Hosp.

C. Length of stay in Baltimore: 6 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-2
D. STREET ADDRESS (If rural, give location): 633 W. Mosher St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	Negro	Single	Aug. 4, 1949			6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Earl Edison
14. MOTHER'S MAIDEN NAME: Debarco Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Atresia of the Duodenal Jejunal Junction

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Congenital Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 8-8-49
19B. MAJOR FINDINGS OF OPERATION: Duodenal Stricture
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 4, 1949 *to* Aug. 10, 1949 *that I last saw the deceased alive on* Aug. 10, 1949, *and that death occurred at* 4 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Olzen M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 8-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/12/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. H. Nelson ADDRESS: 1305 Pennsylvania Ave.

VS 150

157E

G77154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77154

BIRTH NO. G77154

1. NAME OF DECEASED (Type or Print) PETER KEDZIERSKI — 2. DATE OF DEATH 8/10/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Infirmary

C. Length of stay in Baltimore Yrs. 1 Mos. 2 Days 3

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 31 2-3

D. STREET ADDRESS (If rural, give location) 1912 Aliceanna St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	S	July 1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore	USA

13. FATHER'S NAME Joseph Kedzierosky

14. MOTHER'S MAIDEN NAME Lillian Wlodarek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT Cyryl Kedzierski ADDRESS Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured Aneurysm of Abdominal Aorta — INTERVAL BETWEEN ONSET AND DEATH Unknown

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 8/10, 1949 to 8-10, 1949, that I last saw the deceased alive on 8-10, 1949, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert Euson M. D.	Church Home + Hosp.	8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	Aug 13-1949	St Stanislaws	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 11 1949	Huntington Williams M.D.	George A. Weber	307

G77155 BALTIMORE CITY HEALTH DEPARTMENT G77155

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Nannie R. Davis

2. DATE OF DEATH Aug 8-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1639 Abbott

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 1636 abbott Street
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) 1636 Abbott St 7-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	colored	married		52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Gold Sboro N.C.	U S A

13. FATHER'S NAME Geo. W. Reese

14. MOTHER'S MAIDEN NAME Leah Reese

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Odessa D. Thomas	1639 abbott

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 49 days

DUE TO

(B) Arterial Hypertension & CVA

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 20 1949 *to* Aug 8 1949 *that I last saw the deceased alive on* Aug 8 1949 *and that death occurred at* 8 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward Fisher M. D.	1612 Eutaw Monuments	Aug 9 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 11-49	Western Star Cemetery	Catonsville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Robert F. Williams	1515 McElderry St

83a

G771.56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G771.56

BIRTH NO. G771.56

1. NAME OF DECEASED (Type or Print) ETHEL WEAVER

2. DATE OF DEATH 8/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Bet rest

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 703 Druid Hill Ave

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, 11-3
D. STREET ADDRESS (If rural, give location) 703 Druid Hill Ave.

5. SEX F | 6. COLOR OR RACE C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower

8. DATE OF BIRTH May 30, 1904 | 9. AGE (in years last birthday) 45 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Elizabeth City N.C. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Abraham Turner

14. MOTHER'S MAIDEN NAME Nancy Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Bell Brown | ADDRESS Gwynns Falls Rd. Balto Co

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis | INTERVAL BETWEEN ONSET AND DEATH 3 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10, 1946 *to* 8/9/, 1949, *that I last saw the deceased alive on* 8/7/, 1949, *and that death occurred at* 7:20 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE (M. D.) | 23B. ADDRESS 450 W. Biddle St | 23C. DATE SIGNED 8/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/13/49 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn | 24D. LOCATION (City, town, or county) Baltimore (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 11 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR C. Halstead - 918 Druid Hill ave, | ADDRESS

VS 150

931

G77157

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83 G77157

Registered No.

1. NAME OF DECEASED (Type or Print): Leonard P. Blick

2. DATE OF DEATH: August 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 902 Morris Street 11-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Single	12/25/20	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Lawrenceville, Va.	U.S.A.

13. FATHER'S NAME: John Thomas Blick

14. MOTHER'S MAIDEN NAME: Lillian Vaughan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No		John H. Blick-3037 Southland Ave-

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hepatitis, acute c hepatic coma — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 3, 1949, to Aug. 10, 1949, *that I last saw the deceased alive on* Aug 10, 1949, *and that death occurred at* 9:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Fred L. McClintock M. D.	University Hospital	8/10

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	8/13/49	Alberta, Virginia	Alberta, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
AUG 11 1949	Evelyn for Williams M.D.	A. HALSTEAD -918 Druid Hill Ave

VS 150

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G77158

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57 0.3

Registered No. G77158

1. NAME OF DECEASED (Type or Print) Roland Hall

2. DATE OF DEATH 8/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1519 Division
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital
c. Length of stay in Baltimore 32 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-2
D. STREET ADDRESS (If rural, give location) 699 Pitcher Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Married	7/13/87	32	1	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Hall

14. MOTHER'S MAIDEN NAME Emma Fallin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Henry Hall ADDRESS 425 Mosher St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Secondary Shock — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Gangrene of Sigmoid

DUE TO

(C) Volvulus of Sigmoid

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Thrombophlebitis of right leg

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/26/49	Gangrene of Sigmoid & Volvulus	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/26, 1949 *to* 8/8, 1949, *that I last saw the deceased alive on* 8/8, 1949, *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr Marcus W. Moore Sr M. D.	Provident Hospital	8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/12/49	Arbutus Mem Pk.	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 11 1949	Huntington Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave.

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G77159

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77159

1. NAME OF DECEASED (Type or Print) JAMES BAILEY

2. DATE OF DEATH August 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION ("If not in hospital or institution, give street address or location")
Maryland General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-03
D. STREET ADDRESS (If rural, give location) 506 Claggett Alley

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	colored	widowed	Dec. 25, 1888	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): chauffeur
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Thomas Bailey,
14. MOTHER'S MAIDEN NAME: Mary Hudson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-01-2092A

17. INFORMANT: Dora Bailey ADDRESS 1127 W Franklin St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease.
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.:)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED August 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-13-1949	W. H. Auburn Ave	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Kate B Williams ADDRESS 3221 Johnson St

VS 151

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G77160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

002 1 G77160

BIRTH NO.

Registered No. G77160

1. NAME OF DECEASED (Type or Print): James E. Joseph

2. DATE OF DEATH: 9 Aug. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1011 Forrest St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1011 Forrest St 10-1

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan 31 1912
9. AGE (In years last birthday): 37
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Hospital
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James B Joseph
14. MOTHER'S MAIDEN NAME: Elizabeth A Connor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: C A Long 3811 Seven Mile Lane ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, Stomach

DUE TO (B) Advanced pulmonary tuberculosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 9 Aug 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/12/49
24C. NAME OF CEMETERY OR CREMATORY: St Joseph
24D. LOCATION (City, town, or county) (State): Texas Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949
REGISTRAR'S SIGNATURE: [illegible] DECEASED
25. FUNERAL DIRECTOR: Wilhelm Col Inc ADDRESS: 1217 Eutaw St

VS 151

13R

G77161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51 G77161 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Thomas S. Ashley

2. DATE OF DEATH 8/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 645 Washington Blvd
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 645 Washington Blvd
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md 2202
D. STREET ADDRESS (If rural, give location) 645 Washington Blvd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Widower	12/1/1866	82				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Retired
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Wilbur M Ashley
14. MOTHER'S MAIDEN NAME Theresa Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-09-2624

17. INFORMANT Thomas Ashley ADDRESS 1313 N Linwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchial Pneumonia — Interval between onset and death: 1 da

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Carcinoma of Stomach — 2 yr
(C) DUE TO Generalized arteriosclerosis — 5 yr

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-2 1949 to 8-11 1949 *that I last saw the deceased alive on* 8/11 1949 *and that death occurred at* 7:20 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Joseph E Faulkner M. D.
23B. ADDRESS 675 Washington Blvd
23C. DATE SIGNED 8/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/12/49
24C. NAME OF CEMETERY OR CREMATORY Baltimore
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 11 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wilbur Cook
ADDRESS 1217 Eutaw

VS 150

46B

Dr Rangle 21 Hanover Stn Mkt & Charles St at 12:15 PM

G77162

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Reg'd G77162

Registered No.

1. NAME OF DECEASED (Type or Print): PAUL H. HELMEY

2. DATE OF DEATH: Aug. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1737 Hanover St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1737 Hanover St. 22-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Divorced	May 25, 1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Building	Savannah, Ga.	

13. FATHER'S NAME: Charles H. Helmey

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	412-09-3578	Margaret Helmey	Savannah, Ga.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6-8 hrs.

DUE TO

(B) Rt Parotus gland malignancy

DUE TO

(C) Cancerous Growth, Chest. neck.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 28th, 1949 *to* August 11th, 1949, *that I last saw the deceased alive on* 8-11-49, 19____, *and that death occurred at* 12:05 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	642 Wash Pl-t	8-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removel	8/11/49	Millers Chapel	Minehardt, Ga.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 11 1949	Huntington Williams, M.D.	William Cook, Inc.,	1217 St. Paul St.

VS 150

55E

77163 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

17 0 G77163 Registered No.

1. NAME OF DECEASED (Type or Print): AGNES VIRGINIA ROWLES

2. DATE OF DEATH: Aug. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 642 S. Streeper Street
c. Length of stay in Baltimore: 48 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 642 S. Streeper Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	Apr. 17, 1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): A.A.Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: MAREEN DUVALL
14. MOTHER'S MAIDEN NAME: Lavinia Duvall
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Edna Rasel ADDRESS: 642 S. Streeper Street -24

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of breast with Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO
(B)
DUE TO
(C) Chronic Hypertension + arteri-sclerosis (general) — ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 30, 1949, *to* Aug. 10, 1949, *that I last saw the deceased alive on* Aug. 6, 1949, *and that death occurred at* 30 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 2001 E. Pratt St
23C. DATE SIGNED: 8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	8/13/49	Parkwood Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 14 1949
REGISTRAR'S SIGNATURE: [signature] Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND 50

G77164 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-20-1 G77164 Registered No.

1. NAME OF DECEASED (Type or Print): H. LOWREY COOLING

2. DATE OF DEATH: Aug. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4417 Sedgwick Rd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4417 Sedgwick Rd. 27-14-

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Jan. 11, 1897	52 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Editor	Newspaper	Harrington, Kent Co., Del.	

13. FATHER'S NAME: Wm. L. Cooling

14. MOTHER'S MAIDEN NAME: Lucy Satterfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	World War #1	213-03-2942	Mrs. Ruth R. Cooling	4417 Sedgwick Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 40 min
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Aug 10 1949 *to* Aug 10 1949 *that I last saw the deceased alive on* Aug 10 1949, *and that death occurred at* 1:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. W. Hampton M. D.	2 W. Read St	Aug 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/12/49	Lorraine Park	Balto. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 11 1949	Temperton Williams, Jr.	J. TICKNER & SONS	Balto., Md.

VS 150

94a

G77165

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77165

1. NAME OF DECEASED (Type or Print): Mrs Emma Elizabeth Chickering

2. DATE OF DEATH: August 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5503 Fernpark Ave.
c. Length of stay in Baltimore: 86 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 7 - 28 - 02
D. STREET ADDRESS (If rural, give location): 5503 Fernpark Avenue

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: ~~August~~ Sept 29 1863
9. AGE (In years last birthday): 85
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland (Balto.)
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John McLaughlin
14. MOTHER'S MAIDEN NAME: Harriett Heath

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Lester Chickering ADDRESS: 5503 Fernpark Ave - 7 -

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 1947 *to* August 1949 *that I last saw the deceased alive on* August 9 1949 *and that death occurred at* 5 00 p m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.: Millard P. Prahar
23B. ADDRESS: 3400 Woodbine Ave Balt. 7 Md
23C. DATE SIGNED: 8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/13/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

937

G77166 G77166

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Anna L Moss

2. DATE OF DEATH Aug 11 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland 2707 North Calvert
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Her Home 2707 N Calvert
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-23
D. STREET ADDRESS (If rural, give location) 2707 North Calvert

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Aug 23 1870	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Nursing	Hagerstown Md	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George W Doub	Amanda Lissel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Susan D Doub	2707 North Calvert

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Calcified Aortic Stenosis — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

(B) Generalized Arteriosclerosis — Unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9 August, 1949, to 11 August, 1949, *that I last saw the deceased alive on* 10 August 1949, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	2020 Charles St	11 August 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 15 1949	Mt Olivet	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 11 1949	Huntington Williams, M.D.	Howard C Holt	Towanda Pa

VS 150

92a

BIRTH NO. 677167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 677167

1. NAME OF DECEASED (Type or Print): James Cabler

2. DATE OF DEATH: AUG 11 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 0 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Worcester
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Snow Hill
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White		12.31.46	2	8			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: James Cabler

14. MOTHER'S MAIDEN NAME: Ellen Lucas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Glomerular Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 12 mos.
DUE TO Nephrotic Phase.
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-10-, 1948, *to* 8-11-, 1949, *that I last saw the deceased alive on* 8-11-, 1949, *and that death occurred at* 1.30 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Carl Snow Smith M. D.	[illegible]	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Aug 11/49		Snow Hill Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 11 1949	Huntington Williams M.D.	Clay Dennis	Snow Hill Md

1310

G77168

GM, 106923

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77168

1. NAME OF DECEASED (Type or Print): Vegenso Dipietro Or Depitro

2. DATE OF DEATH: 8-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 40 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD,
B. COUNTY: B.C.H. Infirmary
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1203 S. Baylis ST.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 13 1877
9. AGE (In years last birthday): 72 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: (D)
14. MOTHER'S MAIDEN NAME: (D)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Records B.C.H. ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculous Pericarditis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12- 17- 1946, *to* 8- 10- 1949, *that I last saw the deceased alive on* 8- 10- 1949, *and that death occurred at* 1.20 PM, *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Bozzuto M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 8- 11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 8-12-49
24C. NAME OF CEMETERY OR CREMATORY: SACRED HEART CEM
24D. LOCATION (City, town, or county) (State): GERMAN HILL RD.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles S. Zeiler ADDRESS: 901 S. Conkling St

21B

77169 BALTIMORE CITY HEALTH DEPARTMENT G77169

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sister Philomena Huber

2. DATE OF DEATH: 8-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6420 Reisterstown Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Seton Institute

C. Length of stay in Baltimore: 5 Yrs. 8 Mos. 7 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New York
B. COUNTY: Erie
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buffalo
D. STREET ADDRESS (If rural, give location): 2064 Main Street

5. SEX: F
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: 11-14-1883
9. AGE (In years last birthday): 65
If Under 1 Year: Months 8 Days 27
If Under 24 Hours: Hours 17 Min. 10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Religious Sister
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ontario, Canada
12. CITIZEN OF WHAT COUNTRY? -

13. FATHER'S NAME: Joseph Huber
14. MOTHER'S MAIDEN NAME: Mary ? unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT ADDRESS: The Seton Institute

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis, left — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Acute nephritis
Paranoid Schizophrenia — 2

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Aug 11, 1949, to Aug 11, 1949, that I last saw the deceased alive on Aug 11, 1949, and that death occurred at 5:00 P m., from the causes and on the date stated above.

23A. SIGNATURE: John G Bruckner, III M. D.
23B. ADDRESS: Seton Instit. Baltimore
23C. DATE SIGNED: Aug 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-15-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): Buffalo N.Y.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Stewart & Mowen Co.
ADDRESS: Balto.

VS 150

8-3B

7170 BALTIMORE CITY HEALTH DEPARTMENT E 9 29.0 G7717.0

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. N-99.

1. NAME OF DECEASED (Type or Print) MARY GAMBLE

2. DATE OF DEATH August 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 1212 E. Lafayette St. 9-17

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~ (Specify) Widowed
8. DATE OF BIRTH 9/27/1881
9. AGE (In years last birthday) 67 68
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (State or foreign country) Balto
12. CITIZEN OF WHAT COUNTRY? Md.

13. FATHER'S NAME (Unknown) Rhein

14. MOTHER'S MAIDEN NAME (Unknown) Boenzli

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.

17. INFORMANT Harry Gamble 1212 E. Lafayette Ave
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Drowning
DUE TO
(B)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ ~~CAUSE OF~~ DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1212 E. Lafayette St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 10, 1949 ? p. m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Found in bathtub which was filled with water.

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 8/11/49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify) Burial
24B. DATE 8/13/49
24C. NAME OF CEMETERY OR ~~CREMATORY~~ Lorraine
24D. LOCATION (City, town, or county) (State) Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 12 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm Cook Inc. 1217 St. Paul St.
ADDRESS

183

VS 151

77171
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 9-9-8 ✓ Registered No. 77171

1. NAME OF DECEASED (Type or Print) GEORGE FORBES — 14990. — 2. DATE OF DEATH August 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Balto. Gen. Hosp. (do.a)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 701 Sharp Street 22-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	~~White~~ Colored	Single	May 3, 1933	16	3	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Balto	U.S.a

13. FATHER'S NAME: Vernon Forbes
14. MOTHER'S MAIDEN NAME: Ruth Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no	no	—

17. INFORMANT: Ruth Forbes Powell — ADDRESS 701 Sharp

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Drowning.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1400 blk. Frankfurst Avenue Arundel Sand & Gravel Company 25/6
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 10, 1949 ?p.m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR he was floating Slipped from an inner tube on which/

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 8/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Aug 13-49	Mt Calvary	a.a.co. md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: James a Hayes — ADDRESS 142 W. Street

VS 151

183 ✓

72172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77172 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Florence Gassaway

2. DATE OF DEATH Aug. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1317 Madison Ave.
Bar-Wil-Ba Nursing Home
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1317 Madison Ave. 11-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow	May 7, 1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Creek
14. MOTHER'S MAIDEN NAME Martha Peters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Alverta Gordon ADDRESS 459 Roundview Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio-Vascular Renal — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Cerebral Hemorrhage — 1 year
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/5, 19 49, to 8/10, 19 49, that I last saw the deceased alive on 8/10, 19 49, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE W. L. Carlson M. D.
23B. ADDRESS Cockeysville Md
23C. DATE SIGNED 8/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8-13-49
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 12 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mrs. Frances A. Hemsley ADDRESS 578 W. Biddle St.

VS 150

131a

77178

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

S.O.1 G77178

Registered No.

1. NAME OF DECEASED (Type or Print) William Cook

2. DATE OF DEATH August 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 680 Josephine Street 4-0-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	colored	Single	Dec. 15, 1914	34				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Maryland	U. S. A.

13. FATHER'S NAME
George W. Cook

14. MOTHER'S MAIDEN NAME
Ella Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized peritonitis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (B) Ruptured Appendix

DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Aut. & Insp. *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above; and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

Autopsy, Inspection or Inquiry

23A. SIGNATURE Emil Beyer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 9 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-12-49	Mt. Auburn Cem	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 12 1949

REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.

25. FUNERAL DIRECTOR: Mrs Frances A Hemsley — ADDRESS: 578 W. Biddle

VS 151

121

77174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

151 G77174 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mamie Webster

2. DATE OF DEATH Aug. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1106 Druid Hill Av
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore
D. STREET ADDRESS (If rural, give location) 2311 Hunter St. 12 04

5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH July 4, 1881
9. AGE (In years last birthday) 68
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Joseph Cole
14. MOTHER'S MAIDEN NAME Martha E. Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Alice Smith ADDRESS 1106 Druid Hill Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma Stomach
DUE TO
(B)
DUE TO
(C) ulcerated Stomach.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
6 mo.

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* July 1, 1949 *to* Aug 10, 1949 *that I last saw the deceased alive on* Aug 1, 1949 *and that death occurred at* 1 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Anna E. Johnson M. D.
23B. ADDRESS 2329 Gaceford L.
23C. DATE SIGNED Aug 12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8-14-49
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 12 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mrs Frances A. Hemsley ADDRESS 578 W. Biddle

VS 150

46B

7375

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G7773175

Registered No.

1. NAME OF DECEASED (Type or Print) BRITTON S. WILSON

2. DATE OF DEATH August 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital (d.oa.)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 932 Bennet Place 18-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Married	May 5, 1895	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Porter		Maryland	

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Esther Britton ADDRESS 524 Robert St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease - DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		August 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/13/49	Mt. Auburn	Maryland.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 12 1949	Huntington Williams, M.D.	A. Halstead - 9th & Druid Hill Ave	939

VS 151

77176

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

G77176

Registered No.

1. NAME OF DECEASED (Type or Print) Edward L. Blum

2. DATE OF DEATH 8/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland ✓

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balt.
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) 12-01
D. STREET ADDRESS (If rural, give location) 200 Tuscany Rd. (Balt. 10).

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	married	Dec. 19, 1888	60	7	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
merchant	Balt. Salvage store	Baltimore Md	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Likes Blum	Minnie Likes (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mrs Marie Blum	same (wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1-2 minutes

DUE TO (B) Hypertensive cardiovascular disease

DUE TO (C) Arteriosclerosis, generalized — years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of the lung

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August 1, 1949 *to* August 10, 1949, *that I last saw the deceased alive on* August 11, 1949, *and that death occurred at* 5:04 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. F. Coy M. D.	Union Memorial Hospital	8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cem.	12/49	Balto. Hebrew Cem	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 12 1949	Huntington Williams, M.D.	David Fordham & Son	740 Eastern Ave

VS 150

47

71177

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59 G77177

Registered No.

1. NAME OF DECEASED (Type or Print): Samuel James Douglas

2. DATE OF DEATH: August 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Baltimore, Maryland
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Somerset
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Crisfield
D. STREET ADDRESS (If rural, give location): 155 South 4th St., Crisfield, Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Married	Jan. 1, 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Deckhand	Seafarer	Maryland	USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
Unknown		

17. INFORMANT — ADDRESS: Records - US Marine Hospital, Balto., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis, Abdominal — INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/11/49	Inguinal carcinoma metastasis (Biopsy)	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 10, 1949, *to* August 11, 1949, *that I last saw the deceased alive on* August 11, 1949, *and that death occurred at* 10:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Clay Brown, M.D., U.S.P.H.S. for John L. Wilson, Medical Director U.S.P.H.S.	US Marine Hospital, Balto., Md	Aug 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 12, 1949	Tawesia Cem.	Crisfield, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 12 1949	Huntington Williams, Md	Holland Funeral Home	1631 Druid Hill Ave 55E

VS 150

77178 GM. 190101 ✓154 G77178

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Charles E. Hentschel

2. DATE OF DEATH: 8- 10- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3944 Elm Ave. 13-07

5. SEX: M le
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Div.
8. DATE OF BIRTH: Oct. 23 1892
9. AGE (In years last birthday): 56 rs
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mountamance
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Eugene Henschel
14. MOTHER'S MAIDEN NAME: Kathryn Ensley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records B.C.H. 4940 Eastern Ave. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia
DUE TO
(B) Ureteral Obstruction
DUE TO Squamous cell Carcinoma of
(C) rectum & widespread metastases

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION: 7- 24- 1949
19B. MAJOR FINDINGS OF OPERATION: Tumor-
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7- 5- 49 *to* 8- 10- 1949, *that I last saw the deceased alive on* 8- 10-1949, *and that death occurred at* 5.10PM, *from the causes and on the date stated above.*

23A. SIGNATURE: J. L. Dogan M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 8-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 13, 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Paul E. Schenuit Sr. ADDRESS: 1517 Edgewood Ave.

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

Registered No. 77179

1. NAME OF DECEASED (Type or Print): Florence F. Ziegler

2. DATE OF DEATH: Aug. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6 E. Read Street

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6 E. Read Street 11-02

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: About 70
9. AGE (In years last birthday) / If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Ziegler

14. MOTHER'S MAIDEN NAME: Laura J. Woodward

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Edith M. Ziegler — ADDRESS: 6 E. Read St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive failure — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

(B) Arterial hypertension and Cerebral hemorrhage — 10 yrs. / 5 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* [illegible], 19 49 *to* Aug 10, 19 49, *that I last saw the deceased alive on* Aug 10, 1949, *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Herman L. Warsky Jr. M. D.
23B. ADDRESS: 2400 Alameda Blvd
23C. DATE SIGNED: 8/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/13/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 12 1949
REGISTRAR'S SIGNATURE: Hunterton Williams, M.D.
25. FUNERAL DIRECTOR: H. H. Mears and Son. ADDRESS: 805 N. Calvert St

VS. 150

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77180

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77180

Registered No.

1. NAME OF DECEASED (Type or Print): Lewis C. Dix

2. DATE OF DEATH: August 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2079 Druid Park Drive

c. Length of stay in Baltimore: 68 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2079 Druid Park Drive 13-08

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 7, 1871

9. AGE (In years last birthday): 78
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10B. KIND OF BUSINESS OR INDUSTRY: Wm. E. Hooper & Sons Co.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Thomas Dix

14. MOTHER'S MAIDEN NAME: Betty Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-07-9839

17. INFORMANT: Mrs. Evelyn C. Dix
ADDRESS: 2079 Druid Park Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A), STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular Disease — 4 years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 1946, *to* August 10, 1949, *that I last saw the deceased alive on* 8/9, 1949, *and that death occurred at* 10:15 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. H. Townsend Jr. M. D.

23B. ADDRESS: 14 E. Eager St.

23C. DATE SIGNED: 8/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: August 12, 1949

24C. NAME OF CEMETERY OR CREMATORY: Woodlawn

24D. LOCATION (City, town, or county) (State): Baltimore Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR: AUG 12 1949

REGISTRAR'S SIGNATURE: Washington Williams, M.D.

25. FUNERAL DIRECTOR: Burgee Funeral Home

ADDRESS: 3631 Falls Road

VS 150

925

77181

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77181

1. NAME OF DECEASED (Type or Print): Jacob Wesley Wood

2. DATE OF DEATH: August 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 712 W. 34th Street

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 712 W. 34th Street 13-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Dec. 25, 1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Baltimore City	Maryland	U S A

13. FATHER'S NAME: Jacob Reginald Wood

14. MOTHER'S MAIDEN NAME: Sarah Virginia Case

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Mrs. Jennye E. Wood	712 W. 34th Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

(B) Hypertension — 1 year

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 7, 1948, *to* Aug 12, 1949 *that I last saw the deceased alive on* Aug 11, 1949, *and that death occurred at* 2:50 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Conrad Wallenstein M. D.	848 N 36th St	Aug 12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	August 15, 1949	Lorraine Park	Baltimore Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 12 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

937

G77182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77182

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ISAAC LERMAN

2. DATE OF DEATH 8/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI Hospital
c. Length of stay in Baltimore 30 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Balto. city
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 3712 Towanda av. 15-17

5. SEX Male
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M
8. DATE OF BIRTH 1888
9. AGE (In years last birthday) 61 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer Business
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Lerman
14. MOTHER'S MAIDEN NAME Rachel ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Sarah Lerman ADDRESS 3712 Towanda Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Ventricular fibrillation
DUE TO
(B) Coronary occlusion
DUE TO
(C) ASHD

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes Mellitus, CVA

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/11, 1949 *to* 8/12, 1949, *that I last saw the deceased alive on* 8/12, 1949, *and that death occurred at* 9:10 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Wm. Krahmer M. D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 8/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 12, 1949
24C. NAME OF CEMETERY OR CREMATORY Southern Ave
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 12 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Sol Levinson & Bros
ADDRESS 1126 W North Ave

VS 150

61

77383

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 50.0

G77383

Registered No.

1. NAME OF DECEASED (Type or Print): MR JOHN RIDGELY TUCKER

2. DATE OF DEATH: 11 AUG. 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2729 E MADISON ST
c. Length of stay in Baltimore: 74 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~BALTIMORE~~ BALTIMORE
D. STREET ADDRESS (If rural, give location): 2729 E. MADISON ST. 7-0

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: DECEMBER 21 1874
9. AGE (In years last birthday): 74
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TELEGRAPH - OP.
10B. KIND OF BUSINESS OR INDUSTRY: TELEGRAPH.
11. BIRTHPLACE (State or foreign country): BALTIMORE, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MR JAMES TUCKER
14. MOTHER'S MAIDEN NAME: MISS MARY BOHANAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-07-4273
17. INFORMANT: NEICE - MRS MARGARET ~~MAHER~~ TUCKER - SAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ACUTE CONGESTIVE HEART FAILURE
DUE TO
(B) ARTERIOSCLEROSIS
DUE TO
(C) NONE

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION: NONE
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NONE
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): NONE
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): NONE
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): NONE m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? NONE

22. *I hereby certify that I attended the deceased from* 2 AUGUST, 1949 *to* 11 AUGUST, 1949, *that I last saw the deceased alive on* 9 AUGUST, 1949, *and that death occurred at* 3. A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles P. Carey M. D.
23B. ADDRESS: 2722 E. Monument St
23C. DATE SIGNED: 11 Aug. 49

24A. BURIAL ~~CREMATION~~ REMOVAL (Specify): Burial
24B. DATE: aug. 13, 1949
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cem.
24D. LOCATION (City, town, or county) (State): Parkhead & Rosa Lt.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Schumacher Funeral Home Inc.
ADDRESS: 2601 E. Madison St. 921

VS 150

77184

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77184

Registered No.

1. NAME OF DECEASED (Type or Print): Anne Brosh

2. DATE OF DEATH: August 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Calen 4

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 432 N. Rose St 6-0-2

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 1-28-71
9. AGE (In years last birthday): 78
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Bohemia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Clayton Robb
14. MOTHER'S MAIDEN NAME: Anna Botia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Digitalis poisoning
DUE TO
(B) Heart manifested by Severe cardiac arrhythmias
(C) Hypostatic pneumonia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
Hypertensive Cardiovasc. disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 8/5/49 *to* 8/11/49, *that I last saw the deceased alive on* 8/11/49, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edith H. Schwenning M.D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 8/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 13, 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Road

DATE RECEIVED BY LOCAL REGISTRAR: AUG 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR AND ADDRESS: Schumpert Funeral Home 2601 E. Madison St.

VS 150

93D

77185 ✓ E-985 G77185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 77185

BIRTH NO. N-805,0

1. NAME OF DECEASED (Type or Print): John Knowles

2. DATE OF DEATH: Aug. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION, (If not in hospital or institution, give street address or location): 954 Forrest St. Maryland Penitentiary
c. Length of stay in Baltimore: 9 Yrs. 24 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 14-02
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1621 Druid Hill Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	Negro	Single	4-21-1922	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Water Tender		Florida	

13. FATHER'S NAME: Samuel Knowles

14. MOTHER'S MAIDEN NAME: -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-		-	-	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture 5th cervical Vertebra & compression medulla

DUE TO

(B) Legal hanging

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-1- , 19 49 *to* 8-12- , 19 49 *that I last saw the deceased alive on* 8-12- 49 *and that death occurred at* 12:19 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward D. Hollis	Maryland Penitentiary	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-12-49	Sacred Heart	German Hill Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
8-12-49	Huntington Williams, MD	J.J.Fahey & Sons-	1318 Light St.

VS 150

198

G77186 BALTIMORE CITY HEALTH DEPARTMENT G77186

BIRTH NO. G77186 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) JOSEPH L. SHELTON
2. DATE OF DEATH 8/9/49
3. PLACE OF DEATH: A. Baltimore City, Maryland Bretwd
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 908 S. Sharp St.
c. Length of stay in Baltimore Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bretwood
D. STREET ADDRESS (If rural, give location) 908 S. Sharp St. 23-01
5. SEX M 6. COLOR OR RACE C 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 1/2/1889 9. AGE (In years last birthday) 60 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician 10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Washington DC 12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Edward Shelton
14. MOTHER'S MAIDEN NAME Barbra ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.
17. INFORMANT Lillie H. Shelton ADDRESS 908 S. Sharp St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Chronic Myocarditis - INTERVAL BETWEEN ONSET AND DEATH 1 year

DUE TO (B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/10/, 1949 to 8/9/, 1949 that I last saw the deceased alive on 8/8/, 1949, and that death occurred at 5:30 P. m., from the causes and on the date stated above.

23A. SIGNATURE [signature] M. D. 23B. ADDRESS 450 W. Biddle St 23C. DATE SIGNED 8/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) 24B. DATE 8/14/49 24C. NAME OF CEMETERY OR CREMATORY Mt Auburn 24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 12 1949 REGISTRAR'S SIGNATURE Huntington Williams, M.D. 25. FUNERAL DIRECTOR Joseph A. Lively ADDRESS 661 W Baltimore St

VS 150

G77187

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1949 G77187 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Emily Johnson

2. DATE OF DEATH Aug. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 906 Bennett Place
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 16-04
D. STREET ADDRESS (If rural, give location) 906 Bennett Place

5. SEX Female | 6. COLOR OR RACE Col. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH March 15, 1889 | 9. AGE (In years last birthday) 60 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Va. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown | 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Jennie White ADDRESS 906 Bennett Pl.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cachexia + malnutrition — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) Probably carcinoma — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

over

19A. DATE OF OPERATION none | 19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) natural | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) none | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 8-4 1949, to 8-9 ; 1949, *that I last saw the deceased alive on* 8-9, 1949, *and that death occurred at* 3:35 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE George A. Hurst M. D. | 23B. ADDRESS 753 George St. | 23C. DATE SIGNED 8-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug 12, 1949 | 24C. NAME OF CEMETERY OR CREMATORY Mt Auburn | 24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 12 1949 | REGISTRAR'S SIGNATURE Kenneth for Williams, M.D. | 25. FUNERAL DIRECTOR Mrs Katie R. Williams Schroeder ADDRESS 3224

VS 150

55E

GM G77888

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

00 G77188 Registered No.

1. NAME OF DECEASED (Type or Print): John Makowski

2. DATE OF DEATH: 8-11-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Since1888 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write "RURAL" and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3042 Boston ST. 1-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	6-9-1866	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Poland	

13. FATHER'S NAME: Albert

14. MOTHER'S MAIDEN NAME: Marie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Records B.C.H.	4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pulmonary Tuberculosis — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-6-35	Excisian Cataract Left Eye	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-11-1934 *to* 8-11-1949, *that I last saw the deceased alive on* 8-11-1949, *and that death occurred at* 9.10 AM, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	B.C.H. 4940 Eastern Ave.	8-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county), (State)
Burial	Aug. 13-1949	St Stanislaus	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 12 1949	Huntington Williams, M.D.	George A. Weber	705 S. Conn St. 13B (31)

VS 150

G77189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO.

G77189 Registered No.

1. NAME OF DECEASED (Type or Print): IRENE AGNES Schweizer

2. DATE OF DEATH: August 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOCTOR'S HOSPITAL

C. Length of stay in Baltimore: 8 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-01
D. STREET ADDRESS (If rural, give location): 617 N. Curley Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Child	May 29, 1941	8				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Henry Schweizer

14. MOTHER'S MAIDEN NAME: Agnes Johnna Hanafin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: E. F. Schweizer ADDRESS: 617 N. Curley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Bilateral Pneumonia (Bronchial) — 1 day

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-11-, 1949 *to* 8-12-, 1949 *that I last saw the deceased alive on* 8-12-, 1949, *and that death occurred at* 8 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 273 N Charles St
23C. DATE SIGNED: 8 | 12 | 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 16-49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. Vernon Lennon ADDRESS: 4611 Pk. Heights

VS 150

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G77190 ✓ G77190

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153 Registered No.

1. NAME OF DECEASED (Type or Print): ANNIE E. HASENEI

2. DATE OF DEATH: Aug. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 35 N. Streeper St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 35 N. Streeper St. 6-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	May 1, 1871	78 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	

13. FATHER'S NAME: Peter Edler

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—		—

17. INFORMANT: Mr. James Edgar Hasenei — ADDRESS: 35 N. Streeper St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Embole (3 days)
DUE TO Thrombosis of abdom. vein
(B) due to Carcinoma of lower
DUE TO bowel about 1 year
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	YES ☐ No

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	none	none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK / WHILE NOT AT WORK	21F. HOW DID INJURY OCCUR?
none	none	none

22. I hereby certify that I attended the deceased from June 1, 1949 to Aug 10, 1949 that I last saw the deceased alive on Aug 10, 1949 and that death occurred at 4:30 P.M. from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Bernard V. Kelly, M.D.	100 N. Linwood Av	Aug 11 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/13/49	Mt. Carmel Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 12 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

46E

G77191 — G77191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 71

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): MRS. ELSIE V. CRUDDEN

2. DATE OF DEATH: 8-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
C. Length of stay in Baltimore: 8 wks. 2 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): PIKESVILLE #8
D. STREET ADDRESS (If rural, give location): ROSE HILL.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	MARRIED	2-29-20	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		MARYLAND	U.S.

13. FATHER'S NAME: NICHOLAS HENRY ADAMS

14. MOTHER'S MAIDEN NAME: ELEANOR MARQUARDT.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No		Elmer Eugene Crudden - Pikesville

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) GENERALIZED CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: 6 MO.

DUE TO

(B) CARCINOMA OF CERVIX UTERI — 3 YRS.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-27-, 1949, *to* 8-10-, 1949, *that I last saw the deceased alive on* 8-10-1949 *and that death occurred at* 6:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	Maryland Gen. Hosp.	8-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 13-49	Asbury M. E.	Reisterstown Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 12 1949	Huntington Williams, M.D.	Frank A. Merrell	Pikesville Md

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48a

BIRTH NO. B.C. 49-12544 G77192

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

76 Registered No. G77192

1. NAME OF DECEASED (Type or Print): Baby Boy Schilpp

2. DATE OF DEATH: 8-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 27-11
D. STREET ADDRESS (If rural, give location): 5222 Crowson Ave.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: 8-11-49
9. AGE (In years last birthday): If Under 1 Year: Months / Days; If Under 24 Hours: Hours 2 / Min. 10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: WILLIAM G. SCHILPP
14. MOTHER'S MAIDEN NAME: SADIE MARIE GARDNER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2hrs 10 min

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): None m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-11, 1949 *to* 8-12, 19 49, *that I last saw the deceased alive on* 8-12, 1949 *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: George Brown M. D.
23B. ADDRESS: Maryland General Hosp
23C. DATE SIGNED: 8-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 8-13-49
24C. NAME OF CEMETERY OR CREMATORY: MORELAND MEMORIAL
24D. LOCATION (City, town, or county) (State): BALTO. CO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 12 1949
REGISTRAR'S SIGNATURE: Twitty for Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: H. W. JENKINS & SONS CO. 4905 YORK RD.

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G77193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77193 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Miller

2. DATE OF DEATH: 8/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1611 W Saratoga St
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 19-01
D. STREET ADDRESS (If rural, give location): 1611 W Saratoga St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Widowed	4/4/1908	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		South Carolina	

13. FATHER'S NAME: Handy McGregor

14. MOTHER'S MAIDEN NAME: Francis Hudson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Ernest McGregor	1611 W. Saratoga St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
D. P. Zulinski M.D.		8/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	8/12/49	Sumpter S.C.	Sumpter S.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 12 1949	Huntington Williams, M.D.	A. Halstead - 917	Druid Hill 93D Ave.

Medical Examiners case released to Hospital G77194

G77194

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO B.C.H-87561

CERTIFICATE OF DEATH E85.0

Registered No. G77194

1. NAME OF DECEASED (Type or Print): Aurelia Drummond N-9669

2. DATE OF DEATH: Aug. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 8-07
D. STREET ADDRESS (If rural, give location): 1727 E. Biddle St

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 8-17-47
9. AGE (In years last birthday): 1
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Drummond
14. MOTHER'S MAIDEN NAME: Ethel ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lead poisoning — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CERTIFICATION APPROVED BY
William J. McClafferty, M.D.
for: Wm. G. Helfrich M.D.
CHIEF MEDICAL EXAMINER

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1727 E. Biddle Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): August 6, 1949 ? m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Ate paint and plaster off wall

22. *I hereby certify that I attended the deceased from* Aug. 6 *1949 to* Aug. 10, 1949 *that I last saw the deceased alive on* Aug. 10, 1949, *and that death occurred at* 2:10 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE: Wm H. Zuelsdorf
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 8.12.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 13-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: 1000 Brantly ave

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Certificate to be approved by Medical Examiner

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BIRTH NO. G77195

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77195

1. NAME OF DECEASED (Type or Print): Elmer Baker

2. DATE OF DEATH: 8/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home And Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2900 E. Fayette St. 6-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	8/1/1861	88		9

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R.R. Engineer-Retired
10B. KIND OF BUSINESS OR INDUSTRY: Railroad.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Jesse Baker
14. MOTHER'S MAIDEN NAME: Mary Hedrick.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Nancye-Ross Lampe ADDRESS: C.H. & Hosp

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
DUE TO
(B) Chronic Passive Congestion
DUE TO
(C) Arteriosclerotic Heart Disease — 10 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Mitral Cerebral Thrombosis

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 24, 1949 *to* Aug 10, 1949, *that I last saw the deceased alive on* Aug 10, 1949, *and that death occurred at* 9:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: J. T. Means M.D. M. D.
23B. ADDRESS: Church Home & Hospital
23C. DATE SIGNED: 8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: Aug 13/49
24C. NAME OF CEMETERY OR CREMATORY: St Mary's Hampden
24D. LOCATION (City, town, or county) (State): Balto

DATE RECEIVED BY LOCAL REGISTRAR: AUG 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ulman Funeral Home ADDRESS: 2008 Aisquith

VS 150

93D

G77196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16 G77196

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) William Hartwig

2. DATE OF DEATH August 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 602 Stamford Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	March 31 1892	57	4 / 11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY Baltimore Ohio R.R.

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William.

14. MOTHER'S MAIDEN NAME Anna Krause (Anna Krause)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic carcinoma

DUE TO

(B) Bronchogenic CA, Rt. lung ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/3 *1949, to* 8/11 *1949, that I last saw the deceased alive on* 8/11 *1949, and that death occurred at* 7.55 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert L. Levicks M. D.	St. Agnes Hospital	8/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 13/49	Loudon Park	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 12 1949	Hunterstown Williams, M.D.	Ulman Funeral Home	2008 E Orleans St

AG 150

LEVICKAS

47D

G77197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 Registered No. G77197

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William H. Schwartz

2. DATE OF DEATH Aug. 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2238 Cecil Ave.,

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2238 Cecil Ave. 9-08

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH Oct. 6, 1865 | 9. AGE (In years last birthday) 83 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Schwartz

14. MOTHER'S MAIDEN NAME Carolyn Swartz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT Henry Schwartz ADDRESS 2238 Cecil Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

DUE TO

(B) Arteriosclerotic cardiovascular renal disease — 2-3 yrs?

DUE TO

(C) senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1945, to Aug 10, 1949 *that I last saw the deceased alive on* Aug 10, 1949, *and that death occurred at* 6 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE Tudor L. Graziano M. D. | 23B. ADDRESS 1402 Hanford Rd | 23C. DATE SIGNED 8/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug. 13, 1949 | 24C. NAME OF CEMETERY OR CREMATORY St. Matthews | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 12 1949 | REGISTRAR'S SIGNATURE Evelyn for Williams, M.D. | 25. FUNERAL DIRECTOR Ullrich Funeral Home ADDRESS 2008 Orleans St.,

VS 150

131a

G77198 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 31

G77198 — Registered No.

1. NAME OF DECEASED (Type or Print): Euginna Lisberger,

2. DATE OF DEATH: Aug.11th/1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland — Marlborough Apt.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: lifetime (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: same — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 14 of 7
D. STREET ADDRESS (If rural, give location): Marlboro Apts. Eutaw Pl.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	Nov.19th.1864	84	8	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Balto,Md.	

13. FATHER'S NAME: Samuel Lisberger,

14. MOTHER'S MAIDEN NAME: Babette Gutman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
		Miss B.Adler. Marlbo Aprt.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular accident
DUE TO
(B) Cerebral art. disease
DUE TO
(C) ? Hypertension

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. , 1949 *to* 8-11 , 1949 *that I last saw the deceased alive on* , 19 . *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D Bernard Lee M.D.	Marlborough Apt	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	Aug.12th	cremated at Loudon Pk	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 12 1949	Lurington Williams, M.D.	Ward Goodlin & Sons	1902 Eutaw Pl.

VS 150

83a

G77199

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4

G77199

Registered No.

1. NAME OF DECEASED (Type or Print) MARY M. KNODT

2. DATE OF DEATH Aug 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2547 W. Lafayette Ave

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-05
D. STREET ADDRESS (If rural, give location) 2547 W. Lafayette Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	apr 26, 1882	67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	—	Baltimore Md.	

13. FATHER'S NAME Wagner

14. MOTHER'S MAIDEN NAME Heusler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT Catherine M. Knodt ADDRESS 2547 W. Lafayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Endocarditis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Chronic Interstitial Nephritis

DUE TO

(C) Hypostatic Congestion — 2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐, NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1949, *to* Aug 11, 1949, *that I last saw the deceased alive on* Aug 11, 1949, *and that death occurred at* 11.45 P m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. Daly M. D.	817 Medical Arts Bldg	Aug 17 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 15-1949.	London Park	Baltimore City

DATE RECEIVED BY LOCAL REGISTRAR: AUG 19 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS
Mr. & Mrs. John W. Teufel Son - 5311 Edmondson Ave

VS 150

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177200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 177200

BIRTH NO. B.C. 49-16684

1. NAME OF DECEASED (Type or Print) Dorothy Regina Stifler

2. DATE OF DEATH August 12, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hosp. for Women of Maryland. Lafayette & John Sts. Baltimore, Md

C. Length of stay in Baltimore 1 day 15 hrs. 52 min. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 719 Bartlett Ave 9-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	Aug. 10, 1949			1 / 15 / 52

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Maryland	USA

13. FATHER'S NAME: Joseph Norman Royston Stifler

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Phillips

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		None

17. INFORMANT: Mary Elizabeth Phillips, ADDRESS 719 Bartlett Ave Baltimore Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 10, 1949, *to* Aug 12, 1949, *that I last saw the deceased alive on* Aug 12, 1949, *and that death occurred at* 12 M. p. m., *from the causes and on the date stated above.*

23A. SIGNATURE Anna Fogelberg M.D. | 23B. ADDRESS Hosp. for Women of Md. Baltimore Md | 23C. DATE SIGNED Aug 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/13/49 | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn | 24D. LOCATION (City, town, or county) (State) Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 13 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Wilborn & Son | ADDRESS 1217 E. Lond St

VS 150

159

G77201

BIRTH NO. BC. 49-11826

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77201

1. NAME OF DECEASED (Type or Print): Baby Boy Dixon

2. DATE OF DEATH: Aug. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

C. Length of stay in Baltimore: 2 months (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Box 316 A Trumps Hill Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If years, last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	June 13, 1949		1 / 28	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Maryland Gen. Hospital	U.S.A.

13. FATHER'S NAME: August Bartlett Dixon

14. MOTHER'S MAIDEN NAME: Rosslee Hudson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	August Rosslee	Box 316 A Trumps Hill Rd Balt. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Congenital Anomalies — DUE TO

(B) Congenital — DUE TO

(C) Died 6 hrs. after surgical removal of hemangioma of face. (Post operative death).

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: (A) 1 mo 28 da

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8/11/49	Facial Hemangioma with hemmorrhagic parotitis	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9:00 PM 8/11, 1949, *to* 1:45 PM, 1949 *that I last saw the deceased alive on* 8-11, 1949, *and that death occurred at* 2:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. L. Martin Ford, M.D.	Maryland Gen. Hosp.	8-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/13/49	Mt. Olivet	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Huntington Williams, M.D.	Wilson Cook Inc	1217 E. Lord St.

VS 150

157M

077202

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

Registered No. 077202

1. NAME OF DECEASED (Type or Print): Mollie Smith

2. DATE OF DEATH: Aug. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 131 N. Glover St.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 131 N. Glover St. 6-or

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Mar. 24, 1870	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	

13. FATHER'S NAME: Andrew (Unknown)

14. MOTHER'S MAIDEN NAME: Nancy Hartline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No	None	Mrs Josephine Grill, 131 N. Glover St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
ANTECEDENT CAUSES
(B) Arterio sclerosis — several years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/6 '49 *to* Aug 8th, 1949 *that I last saw the deceased alive on* Aug 8th, 1949 *and that death occurred at* 7a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry L. Tandler M. D.	1002 N. Mellon ave	8/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/13/49	St. Peters	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
AUG 13 1949	Hunter for Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

83a

G77203

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163

G77203

Registered No.

1. NAME OF DECEASED (Type or Print) Robert Patsy Donovan

2. DATE OF DEATH Aug. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Baltimore, Maryland

c. Length of stay in Baltimore — Yrs. Life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 918 E. Biddle Street 10-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Div.	Nov 3, 1903	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Welder		Maryland	USA

13. FATHER'S NAME: Dennis Donovan

14. MOTHER'S MAIDEN NAME: Mary Weber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes		215-01-4996	Records - US Marine Hospital	Balto., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, right lung — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Duration unknown

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* April 8, 1949, *to* August 11, 1949, *that I last saw the deceased alive on* Aug. 11 1949, *and that death occurred at* 1:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Medical Director M. D.	US Marine Hospital, Balto., Md.	8-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/16/49	National	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 13 1949	Municipal Registrar, Md.	Wilson & Son Inc	1217 Park St

VS 150

47D

G77209

BIRTH NO. G77209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-20-1

Registered No.

1. NAME OF DECEASED (Type or Print): HOWARD B. BAKER

2. DATE OF DEATH: AUG. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3211 MAGNOLIA Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3211 MAGNOLIA Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	October 6, 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Eng. Gas & Electric		Maryland.	

13. FATHER'S NAME: Henry Baker

14. MOTHER'S MAIDEN NAME: ? Billips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Crosby	3211 Magnolia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour

DUE TO

(B) ARTERIOS Chronic Hypertensive

DUE TO

(C) Cardio Vascular Disease — 10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 9, 1949 *to* Aug 9, 1949, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 6:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Berdenasky M. D.	257 Monroe St	Aug 10 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	7/13/49	Mt. Olivet	Frederick Ave Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 13 1949	Huntington Williams, M.D.	John F. Denny Inc	711 Light St.

VS 150

937

G77205

BIRTH NO

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77205

1. NAME OF DECEASED (Type or Print) James Hayes

2. DATE OF DEATH August 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 7 Yrs. — Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE N.Y.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Norwich
D. STREET ADDRESS (If rural, give location) 86 N. Broad St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	8-27-10	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		N.Y.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Arthur Hayes	Pearl Gage

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anemia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

(B) Radiation Sickness for

(C) Seminoma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-6, 1949, *to* 8-12, 1949, *that I last saw the deceased alive on* 8-12, 1949 *and that death occurred at* 3 55 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas N. Johns M. D.	JOHNS HOPKINS HOSPITAL	8/12

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-16-1949	Riverside Cemetery	S. New Berlin, N.Y.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 13 1949	Huntington Williams, MD	John O. Mitchell & Sons	1900 Eutaw Place

VS 150

51C

G77206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

475

G77206

BIRTH NO. B.C. 49-16705 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Nancy Carole Yeaton

2. DATE OF DEATH: 8.12.49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospi

c. Length of stay in Baltimore: Yrs. 1 Mos. 22 Days —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore. 16-06
D. STREET ADDRESS (If rural, give location): 2702 Prospect St. Balto. 16. Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W.	CHILD	6/20/49		1	22		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	

13. FATHER'S NAME: James K. Yeaton

14. MOTHER'S MAIDEN NAME: Beatrice DEALE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	NO	MR JAMES K. YEATON	2702 PROSPECT ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Upper Respiratory Infection.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 9th, 1949, *to* August 12th, 1949, *that I last saw the deceased alive on* August 12th, 1949, *and that death occurred at* 1.05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Carlos J. Castellano M. D.	Bon Secours Hospital	9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8/15/49	WESTERN	BALTIMORE MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 13 1949	Newton Jon Williams, MD	J.T. STANSBURY	2700 EDMONDSON AVE

VS 150

1042

77207

BIRTH NO. B.C. 48-14418

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

491 Registered No. 77207

1. NAME OF DECEASED (Type or Print): DOWNS ROBERT

2. DATE OF DEATH: August 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days 13

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1116 Stoddard Court 11-04
D. STREET ADDRESS (If rural, give location): Baltimore Maryland

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 6-28-48
9. AGE (In years last birthday): 1 year
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Robert Downs
14. MOTHER'S MAIDEN NAME: Margie Dyson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Father
ADDRESS: 1116 Stoddard Ct.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute bilateral bronchio pneumonia
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 24 hours

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. I hereby certify that I attended the deceased from August 11, 1949, to August 11, 1949, that I last saw the deceased alive on Aug. 11, 1949, and that death occurred at 5:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE: Charles T Henderson M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: August 11

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 13, 1949
24C. NAME OF CEMETERY OR CREMATORY: St Peters
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 13 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 150

107

G77208

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

491 G77208 Registered No.

1. NAME OF DECEASED (Type or Print) Robert Wood

2. DATE OF DEATH August 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore 42 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-01
D. STREET ADDRESS (If rural, give location) 532 W. Biddle St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Married	8-22-1877	71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Wood

14. MOTHER'S MAIDEN NAME Ida Willis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-03-9356

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Pulmonary infarction — 2

DUE TO

(C) Pulmonary thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-21 1949 *to* 8-10 1949, *that I last saw the deceased alive on* 8-10 1949, *and that death occurred at* 5:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Jack M. Burnett M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED Aug 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8-13-49

24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 13 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR'S ADDRESS 518 W Biddle St Mrs Frances A Hensley

VS 150

107

77209

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77209

Registered No.

1. NAME OF DECEASED (Type or Print): I de Levin

2. DATE OF DEATH: 8/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 17 S. Ann St
C. Length of stay in Baltimore: 50 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 17 S. Ann St 2-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	1874	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Abraham Wenshal
14. MOTHER'S MAIDEN NAME: Hinda ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Mollie Jacobs ADDRESS 2201 E Baltimore St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C. Vdisease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: B. Lubinski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 8/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 14, 1949	Adas Israel Beth Isaac Cem	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Sol Levinson & Bros ADDRESS 1126 W North Ave

VS 151

93D

G77210

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77210

1. NAME OF DECEASED (Type or Print): ALAN Robert Tyson

2. DATE OF DEATH: August 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2927 Winchester St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2927 Winchester St. 16-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 hours: Hours	Min.
M	W	Married	5-14-1902	47	2	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Gas Service Sta.	York, Penna.	U.S.A.

13. FATHER'S NAME: Wm. H. Tyson

14. MOTHER'S MAIDEN NAME: Edith Zimmerman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—		Wife	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
Julian J. McClafferty M.D.		August 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-15-49	Stelting	York Co., Penna.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Wm. J. Tickner & Sons	Balto. Md.

VS 151

94a

G77211
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77211
Registered No.

1. NAME OF DECEASED (Type or Print) JOHN W. KLAUS

2. DATE OF DEATH August 11, 1949

3. PLACE OF DEATH: Baltimore City, Maryland
A. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital
B. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY A. A. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orchard Beach
D. STREET ADDRESS (If rural, give location) --

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widowed	Mar. 18, 1889	60 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Woodlawn, Md.	

13. FATHER'S NAME: William Klaus

14. MOTHER'S MAIDEN NAME: Unknown Lebinau

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Mr. C. H. Klaus — ADDRESS: 6821 Dogwood Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion
DUE TO
(B)
DUE TO
(C)

II — ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George D. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: August 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/15/49	Lorraine Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Permit for Williams, M.D.
25. FUNERAL DIRECTOR: WILLIAM J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 151

94a

G77212

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77212

Registered No.

1. NAME OF DECEASED (Type or Print): H. ROSS COPPAGE

2. DATE OF DEATH: Aug. 11, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bergner Mansion Gwynns Falls Park.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Bergner Mansion - Gwynns Falls Park.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
male	white	married	Jan. 24, 1884	65 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dentist		St. Mary's Co., Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Stephen Coppage	Charlotte Guyther

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		no	Mrs. Mabel Fallin Coppage	Bergner Mansion Gwynns Falls Park

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the Gall Bladder — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June 1949	Carcinoma of the gall bladder & liver metastases	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 20, 1949 *to* Aug 11, 1949 *that I last saw the deceased alive on* Aug 11, 1949 *and that death occurred at* 7:35 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	1109 St Paul St	8/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/15/49	Poplar Hill Cem.	St. Mary's Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 13 1949	[signature] for Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

46F

G77213

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77213

1. NAME OF DECEASED (Type or Print): MINNIE L. WILLIAMS

2. DATE OF DEATH: Aug. 12, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION: (If not in hospital or institution, give street address or location) 3032 Gwynns Falls Pkwy.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3032 Gwynns Falls Pkwy.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Mar. 17, 1873
9. AGE (In years last birthday): 76 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William T. Wallett
14. MOTHER'S MAIDEN NAME: Mary Stokes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mr. George W. Williams
ADDRESS: 3032 Gwynns Falls Pkwy.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis
DUE TO Cardio Vascular disease due to
(B) Senility - Cerebral
DUE TO Thrombosis
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 8 1947 *to* Aug 12 1949, *that I last saw the deceased alive on* Aug 12 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 3033 W North Ave
23C. DATE SIGNED: 8/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/15/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, Md
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

93D

G77214

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ X 18

G77214 Registered No.

1. NAME OF DECEASED (Type or Print) LOUIS JAMES BURLEIGH

2. DATE OF DEATH 8-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY BALTO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) CATONSVILLE
D. STREET ADDRESS (If rural, give location) 14 DUTTON AVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
M	W	M	8-12-1876	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
sales Mgr. (Rtd)		PENNSYLVANIA (Phila.)	USA

13. FATHER'S NAME: WINFIELD SCOTT BURLEIGH

14. MOTHER'S MAIDEN NAME: CORINNA FLORENCE WEST

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Mrs. Charlotte M. Diek	304 W. Monument St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) metastasis from — INTERVAL BETWEEN ONSET AND DEATH: Feb 8, 49
DUE TO
(B) Adenocarcinoma of bladder — Aug 11, 1949
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
uremia

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2/9/49 4/12/49	Carcinoma of bladder	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-11, 1949, *to* 8-11, 1949 *that I last saw the deceased alive on* 8-11, 1949, *and that death occurred at* 8:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Charlton Gropbeal M. D.	Union Memorial Hospital	8-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/13/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 13 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

52B

G77215

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77215

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Conrad Carl

2. DATE OF DEATH: Aug 11/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Middleborough, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5440 Belair Rd. Garden Vil Conv. Home

C. Length of stay in Baltimore: 60. Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): Essex 21 Md.

5. SEX: M

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: 6/8/65

9. AGE (In years last birthday): 84 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: Elizabeth Walch.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: H.J. Mueller ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-sclerotic Cardio-

DUE TO Vascular Renal Disease

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

19A. DATE OF OPERATION: no

19B. MAJOR FINDINGS OF OPERATION: no

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): no

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): no

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): no m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? no

22. *I hereby certify that I attended the deceased from* July, 1948, to Aug. 11, 1949 *that I last saw the deceased alive on* Aug 11, 1949 *and that death occurred at* 7:20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: James F. White M. D.

23B. ADDRESS: 422 Eastern Ave. Balto 21, Md.

23C. DATE SIGNED: 8/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 8/16/49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park.

24D. LOCATION (City, town, or county) (State): Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 13 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: J. Brzozowski ADDRESS: 1407 Eastern Ave

VS 150

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77216

✓ E-985
N-805.0 G77216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G 77216

1. NAME OF DECEASED (Type or Print): Eugene H. James

2. DATE OF DEATH: Aug. 12, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Penitentiary-954 Forrest St.
c. Length of stay in Baltimore: 9 mos.-1 day (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 27-17
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3311 Paton Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Negro	Single	4-25-1917	32				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Eugene James
14. MOTHER'S MAIDEN NAME: Bessie Thompson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Penitentiary Record-954 Forrest St. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture 5th cervical Vertebra &
DUE TO Compression spinal cord

(B) Legal hanging
DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-1- , 1949, *to* 8-12- , 1949 *that I last saw the deceased alive on* 8-12-1949 *and that death occurred at* 12:42AM *from the causes and on the date stated above.*

23A. SIGNATURE AND M. D. — 23B. ADDRESS: Maryland Penitentiary — 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-16-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): A.A. Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR: 8-13-49
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR — ADDRESS: Rayner Sanders-1412 E. Preston St.

VS 150

198

G77217

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 49 G77217

1. NAME OF DECEASED (Type or Print) Nora Proctor.

2. DATE OF DEATH August 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1931 E Jefferson St

c. Length of stay in Baltimore 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-04
D. STREET ADDRESS (If rural, give location) 1931 E Jefferson St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (Years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C.	Widowed	Sept 13 1902	46	10	27

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work.
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) North Carolina U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Calvin Maxwell
14. MOTHER'S MAIDEN NAME Mattie Moxon,

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Oneswby 1931 ADDRESS Jefferson St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Virus Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 4 days

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August 7 19 49 *to* August 11 19 49 *that I last saw the deceased alive on* August 11 19 49 *and that death occurred at* 6:15 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Maurice Short M. D.	1431 Mansfield Ave	Aug 11 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/13/49	U.S Balto National	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 13 1949	Huntington Williams, M.D.	Rayner Sanders	1092 1412 E. Preston St

VS 150

G77218

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4:50 P

Registered No. G77218

1. NAME OF DECEASED (Type or Print): Lila Chapman (Lillie Chatmon)

2. DATE OF DEATH: August 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1128 Pennsylvania Ave.

17-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Widown	Sept. 15, 1886	62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	CHURCH	South Carolinia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Rev. G.M. Edwards	1124 Penn. Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arterio-Sclerosis	
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L Boyer M.D.		August 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 13, 1949	Mt. Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 13 1949	Huntington Williams, M.D.	ELROY O. WILSON	1000 Brantly Ave.

VS 151

97

G77219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77219

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles A. Harding

2. DATE OF DEATH: Aug-11-1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 626 S. Monroe St.

b. Length of stay in Baltimore: Yrs. 20 Mos. 0 Days 3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 626 S. Monroe St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Jan-6-1868	81				

10A. USUAL OCCUPATION (Give kind of work, done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Conductor	B+O-R.R.	Howard Co. Md.	U.S.A.

13. FATHER'S NAME: Charles Harding

14. MOTHER'S MAIDEN NAME: Ellen Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Alma Harding.	(Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Senility

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 25, 1949, *to* Aug. 10, 1949, *that I last saw the deceased alive on* Aug. 10, 1949, *and that death occurred at* 8:35 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
DeWitt Laughlin M. D.	4508 Edmondson Village	8/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug-13/49	Loudon Park	Balto-Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 13 1949	Thurlington Williams, M.D.	F. E. Hilbert & Son.	800 Eutaw

VS 150

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G77220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

434.1 Registered No. G77220

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Kenneth Fisher

2. DATE OF DEATH: August 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Davidson Chemical Company
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marley Neck
D. STREET ADDRESS (If rural, give location): Solley Road (Glenburnie P.O. Md).

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	MARRIED	2-16-1896	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	CHEMICAL WORKER	MARYLAND	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
THOMAS FISHER	HARRIETT SPENCER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WORLD WAR I		PICOLIA FISHE - GLENBORNIE, P.O. MD.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute congestive cardiac failure
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Emphysema of lungs
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR
23C. DATE SIGNED: August 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-14-49.	HALLS METH. CHURCH	MARLEY, A.A. CO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Wm. A. Jackson - 916 Penna. Ave.

VS 151

93E

77221

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 77221

1. NAME OF DECEASED (Type or Print) HORACE CARROLL

2. DATE OF DEATH August 10, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Poplar Ridge (A. A. Co. Md.)
D. STREET ADDRESS (If rural, give location) MAGOTHY BEACH ROAD (JACOBSVILLE).

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	MARRIED	12-22-1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	GARAGE	A. A. Co., MARYLAND.	

13. FATHER'S NAME
UNKNOWN

14. MOTHER'S MAIDEN NAME
UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		MARY HALL - MAGOTHY BEACH ROAD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute pulmonary edema
DUE TO
(B) Arteriosclerotic cardiovascular disease.
DUE TO
(C)

II — ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE George A. Merrill M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED 8/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-14-49.	MAGOTHY.	JACOBSVILLE, A. A. Co., MD.

DATE RECEIVED BY LOCAL REGISTRAR AUG 13 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS
Wm. A. JACKSON - 916 PENNA. AVE.

VS 151

93D

G772222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

343 G772222

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Eva Movshovich

2. DATE OF DEATH: AUG 12 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: N.Y. B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brooklyn
D. STREET ADDRESS (If rural, give location): 884 43rd St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	3.26.04	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Meyer Simon
14. MOTHER'S MAIDEN NAME: Clara Brawsky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fever of undetermined etiology — INTERVAL BETWEEN ONSET AND DEATH: 6 wks.

DUE TO

(B) Cardiac decompensation, chronic, cause undetermined — 6 mos.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Thoracotomy, left, exploratory

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8/11/49	Nothing significant	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7.12. 1949 *to* 8.12. 1949, *that I last saw the deceased alive on* 8.12. 1949, *and that death occurred at* 2.15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert W. Ruffin Jr. M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	8-13-49		Newyork N.Y.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 14 1949	Huntington Williams, MD	Jack Rewis Inc	2100 Eutaw Pl

VS 150

95c

G77223 — 77223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G77223 — Registered No. 174

1. NAME OF DECEASED (Type or Print): Nannie Gross.

2. DATE OF DEATH: August 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 837 Harlem Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 837 Harlem Ave
C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 837 Harlem Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 837 Harlem Ave. 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	C	married	Jan. 15, 1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Eastern Shore, Md.,	

13. FATHER'S NAME: Thomas Gross

14. MOTHER'S MAIDEN NAME: Matilda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Nathan Gross	837 Harlem Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of Uterus — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Secondary Anemia — DUE TO — ?

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Jan 1948	Carcinoma Uterus	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Jan 3, 1948 to Aug 10, 1949, that I last saw the deceased alive on Aug 10, 1949, and that death occurred at 6:12 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. McDonald M. D.	844 N Carey st	8/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, cemetery) (State)
Burial	8-13-49	W H Carlin's Son	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 14 1949	Hunter for Williams, M.D.	Mrs Katie R Williams	332 N Schroeder St

48B

G77224

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77224 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Dr Joseph D. TALICIN

2. DATE OF DEATH 8/13/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General

C. Length of stay in Baltimore 65 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 524 Eutaw Place

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH | 9. AGE (In years last birthday) 69 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician | 10a. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Nathan

14. MOTHER'S MAIDEN NAME Rachael

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT Marie Talkin ADDRESS 524 Eutaw Pl

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atherosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE John R Watts M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED 8/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24B. DATE 8-15-49 | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) New York N. Y.

DATE RECEIVED BY LOCAL REGISTRAR AUG 14 1949 | REGISTRAR'S SIGNATURE Williams, M.D. | 25. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

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G77225 G77225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Meyerwitz, Mollie

2. DATE OF DEATH 8/13/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore, Inc.

C. Length of stay in Baltimore 43 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 8-04

D. STREET ADDRESS (Rural, give location) 2201 E. Preston St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married		64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Moses

14. MOTHER'S MAIDEN NAME Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Jacob Meyerwitz ADDRESS 2201 E. Preston

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cerebrovascular Accident

DUE TO

(C) Generalized Arteriosclerosis

Pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/5/49 *, 19*49 *to* 8/13 *, 19*49 *that I last saw the deceased alive on* 8/13 *, 19*49 *, and that death occurred at* 7:10 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE Allen Lowley MD M. D. | 23B. ADDRESS Sinai Hosp | 23C. DATE SIGNED 8/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-14-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS 2100 Eutaw Pl

83a

677226 Lloyd Vance Steurgill ✓ 677226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. E 43 X

Registered No.

1. NAME OF DECEASED (Type or Print) Lloyd Vance Steurgill N-948

2. DATE OF DEATH Aug. 13, 1949.

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.

C. Length of stay in Baltimore 7 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE maryland B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
D. STREET ADDRESS (If rural, give location) Glyndon (Willow Glen Farm)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	April 11, 1916	33				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Hand	Farming	Piney Creek N. C.	U. S.

13. FATHER'S NAME: Fred Steurgill

14. MOTHER'S MAIDEN NAME: Cordia White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
?	?	?		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Burns 2nd & 3rd° 60% Body — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	farm	Willow Glen Farm, Glyndon, Maryland

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 13, 1949 3.15 p.m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Tractor exploded during repair

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry, *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Emil Beyer M.D.		17 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	8/15/49	Wm. Williams, Md.	Piney Creek N. C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 14 1949		Wm. J. Tickner & Sons	Balt., Md.

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G77227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17 G77227 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Meyer Butler. | 2. DATE OF DEATH 8-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Doctors Hospital —
c. Length of stay in Baltimore Un known — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland | B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore — 15, 2
D. STREET ADDRESS (If rural, give location) 3833 Park Heights Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White ~~Negro~~	married.	1874	74	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant		Russia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Un known	Un known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Sarah Butler	3833 Park Heights

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the prostate — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestion Cart failure.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 20, 1949 *to* Aug 14, 1949, *that I last saw the deceased alive on* Aug 14 1949 *and that death occurred at* 2.45 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert L. Glass M. D.	Doctors Hospt	Aug 14, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/14/49	Mt Carmel	Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 14 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eastern Ave

(S-150)

516

Dr. Grott G77228 BALTIMORE CITY HEALTH DEPARTMENT 443 G77228

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Ida L. Pangborn

2. DATE OF DEATH: Aug. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Edgwood Nursing Home 6000 Bellona Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Parkville
D. STREET ADDRESS (If rural, give location): 3041 Parktowne Road

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: MARCH 19-1873
9. AGE (In years last birthday): 76
If under 1 year: Months / Days
If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Indianapolis, Indiana
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Henry Niermeyer
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Helene Williams, ADDRESS: 3041 Parktowne

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO
(B) Hypertensive CVD — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 47, *to* Aug 13, 1949, *that I last saw the deceased alive on* Aug 13 1949, *and that death occurred at* 10 20 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harold A. Grott M.D.
23B. ADDRESS: 8100 Harford Rd.
23C. DATE SIGNED: 8/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-16,-49
24C. NAME OF CEMETERY OR CREMATORY: Crown Hill Cem.
24D. LOCATION (City, town, or county) (State): Indianapolis Indiana

DATE RECEIVED BY LOCAL REGISTRAR: AUG 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, 5305 Harford Road.

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93D

Dr. Marston
516 Cathedral St.

G77229

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

Registered No. G77229

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Louise Drane

2. DATE OF DEATH: Aug. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Edgewood Nursing Home, 6000 Bellona Avenue

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Prince Georges
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): University Park
D. STREET ADDRESS (If rural, give location): 4306 Sheridan Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	widowed	June 21, 1861	88				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Henry Langemann

14. MOTHER'S MAIDEN NAME: Mary Louise Schneider

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. J.L. Rebbel ADDRESS: 1519 Northgate Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 2½ days.

DUE TO

(B) Arteriosclerosis General.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none

19B. MAJOR FINDINGS OF OPERATION: none.

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): none

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): none.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?: no injury.

22. *I hereby certify that I attended the deceased from* Aug 4th, 1949, to Aug 12, 1949, *that I last saw the deceased alive on* Aug 12, 1949, *and that death occurred at* 5.30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: James Graham Marston M. D.

23B. ADDRESS: 516 Cathedral St.

23C. DATE SIGNED: 8-13-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-15-49	Baltimore Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, 5305 Harford Road.

Vs 150

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G77230 BALTIMORE CITY HEALTH DEPARTMENT G77230
CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WALTER P. MYERS — N-991 MP

2. DATE OF DEATH August 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3049 Fleetwood Avenue — 7-05 MP

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH Dec. 1, 1891
9. AGE (In years last birthday) 57 MP — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) York Co, Pa.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Benjamin F. Myers
14. MOTHER'S MAIDEN NAME Edith M. Phfeiffer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-03-2605
17. INFORMANT — ADDRESS Mr. W. Vernone Myers, 2911 Hiss Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation by hanging.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3049 Fleetwood Avenue MP
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 11, 1949 m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Hanged self by rope from water pipe

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED August 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8-15-49
24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 14 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR — ADDRESS Leonard J. Ruck, 5305 Harford Road

VS 151

164a

G77231 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E983 G77231 Registered No.

1. NAME OF DECEASED (Type or Print) IRMA C. MYERS — N-991 MP

2. DATE OF DEATH August 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
St. Joseph's Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3049 Fleetwood Avenue 27-05 MP

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	March 1, 1894	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Maximillian Schanze
14. MOTHER'S MAIDEN NAME: Josephine Scharoun

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Mr. W. Vernon Myers, 2911 Hiss Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation by strangulation (rope) — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Multiple contusions and lacerations.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3049 Fleetwood Avenue MP
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): August 11, 1949 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Strangled with rope

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: August 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-15-49	Parkwood Cem.	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: AUG 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Leonard J. Ruck, 5305 Harford Road.

VS 151

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G77232 ✓ G77232

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 776 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Sullivan

2. DATE OF DEATH: Aug. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR ~~INSTITUTION~~ (If not in hospital or institution, give street address or location): St. Joseph's
c. Length of stay in Baltimore — Yrs. Mos. Days: 1 da.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 259 S. East Ave. 26-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	Single	Aug. 1, 1949			8 / 10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant		St. Joseph's Hospital	

13. FATHER'S NAME: William Howard Sullivan

14. MOTHER'S MAIDEN NAME: Dorothy June Wise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 11, 19~~49~~, *to* Aug. 11, 1949, *that I last saw the deceased alive on* Aug. 11, 1949, *and that death occurred at* 12:20 m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
Vito L. Coppa	1400 N. Caroline St.	Aug. 11, 19

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	aug 15, 1949	Holy Redeemer	Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 14 1949	Washington Williams M.D.	Edward J. Ruth 5305 Harford

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G77233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

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G77233

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Willia m H. Bishop

2. DATE OF DEATH: 8/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 607 N. Bentalou St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 47yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltmore Md
D. STREET ADDRESS (If rural, give location): 607 N. Bentalou St. 1605

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct. 2, 1871
9. AGE (In years last birthday): 77
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New Bern N. Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Bishop
14. MOTHER'S MAIDEN NAME: Jane Kilpatrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Miss Geneva Dimpsey ADDRESS: 607 N. Bentalo S

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-15, 1947, *to* 8-13, 1949, *that I last saw the deceased alive on* 8-13, 1949, *and that death occurred at* 10:45 *p* m., *from the causes and on the date stated above.*

23A. SIGNATURE: Daniel J Schwartz M. D.
23B. ADDRESS: 2320 Eutaw Place
23C. DATE SIGNED: 8-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 8/14/49
24C. NAME OF CEMETERY OR CREMATORY: New Bern N. Carolina
24D. LOCATION (City, town, or county) (State): N. Carolina

DATE RECEIVED BY LOCAL REGISTRAR: AUG 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. J. Tickner & Sons ADDRESS: N. & Pa. Aves

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Correct age is expecially important. Physician: please write plainly.

G77234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16 Registered No. G77234

BIRTH NO.

1. NAME OF DECEASED (Type or Print) THOMAS W. ROBERTSON

2. DATE OF DEATH Aug 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1729 S. Hanover St

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1229 James St 21-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widower	May 7 1875	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chimney Sweeper

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME David F. Robertson

14. MOTHER'S MAIDEN NAME Sarah A. Zipp.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Mrs. Ethel Reeves 1729 S. Hanover St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Brendwegenic Carcinoma	5-25-48 1 yr 3 mo
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-21- 1948, *to* 8-12 1949, *that I last saw the deceased alive on* 8-12 1949, *and that death occurred at* 6 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE John P. Mulvihill Jr M. D.

23B. ADDRESS 1227 Wash. Blvd

23C. DATE SIGNED 8-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Aug 15/49

24C. NAME OF CEMETERY OR CREMATORY Western

24D. LOCATION (City, town, or county) (State) Edmondson Ave md

DATE RECEIVED BY LOCAL REGISTRAR AUG 14 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR, ADDRESS Euston E. Donovan 3818 Roland ave

VS 150

47c

correct age is especially important. Physicians, please write plainly.

G77235

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 49-16654 **CERTIFICATE OF DEATH** 10-1 Registered No. G77235

1. NAME OF DECEASED (Type or Print): (Baby) Ray Glenn Doss

2. DATE OF DEATH: August 13, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Mt. Washington
D. STREET ADDRESS (If rural, give location): 2416 2614 Crest Rd 27-15

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug 10, 1909
9. AGE (In years last birthday): 3 | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto, Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Roger D. Doss
14. MOTHER'S MAIDEN NAME: Hazel E. Enos
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Roger Doss. ADDRESS: 2416 Crest Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pernicious
DUE TO
(B) Erythroblastosis Fetalis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-10, 1949 *to* 8-13, 1949 *that I last saw the deceased alive on* 8-13, 1949 *and that death occurred at* 8:20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Judith B. Landau M. D.
23B. ADDRESS: Sinai Hospital Baltimore
23C. DATE SIGNED: 8-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/15/49
24C. NAME OF CEMETERY OR CREMATORY: Warder Chapel
24D. LOCATION (City, town, or county) (State): Liberty Rd Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Loring Byers ADDRESS: 5005 Pk Heights Ave

VS 150

161C

G77236

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C.48-17725

CERTIFICATE OF DEATH

Registered No. G77236

1. NAME OF DECEASED (Type or Print): Pritchard, LORENA

2. DATE OF DEATH: 8-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore: 11 (Years / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Brooklyn Park
D. STREET ADDRESS (If rural, give location): 5207 Brookwood Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	Aug 18 1948		11 / 25	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Maryland	U.S.

13. FATHER'S NAME: Pritchard Ellsworth Lee

14. MOTHER'S MAIDEN NAME: Thompson, Alice E. ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Father	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acidosis — DUE TO

ANTECEDENT CAUSES

(B) Dehydration — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Acute enteritis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hydrocephalus

INTERVAL BETWEEN ONSET AND DEATH: Hours

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no		

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* — 19__, *to* — 19__, *that I last saw the deceased alive on* 8-13, 1949, *and that death occurred at* 2:55 *H* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward Senger — M. D.	Franklin Square Hospital	8-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/15/49.	Cedar Hill	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Wilson Co. Inc.	1219 Park St

VS 150

157a

G77237

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 935.0 G77237 Registered No.

1. NAME OF DECEASED (Type or Print) PAULINE HEPPDING — N-984 — 2. DATE OF DEATH August 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Point Pleasant
D. STREET ADDRESS (If rural, give location) Furnace Branch Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
female	white	Married	July 12, 1925	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	

13. FATHER'S NAME Floyd Lewis
14. MOTHER'S MAIDEN NAME Esther (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	none	Howard Hepding	Furnace Branch Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Electrocution by lightning.
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	Point Pleasant, Md.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 12, 1949 9p m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Struck by lightning

52-00

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		August 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/16/49	Glen Haven	Glen Burnie Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Wilhom Cook Inc	1217 Hanover St

192

VS 151

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77238 X ✓ G77238

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3 32

Registered No.

1. NAME OF DECEASED (Type or Print): ALFRED BESSLING

2. DATE OF DEATH: AUG 12 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balt. Gen'l Hosp
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY Balto
1305 Birch Ave #27
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt. Arbutus
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	WIDOWED	OCT 17 1869	79 80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	City of Balto	Balto MD	

13. FATHER'S NAME: Albert Bessling

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Mrs. Minnie Brenner 1305 Birch Ave Arbutus

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebro-Vascular Thrombosis	10 hrs
DUE TO (B)	Generalized Arteriosclerosis	Many Years
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Benign Prostatic Hypertrophy	Years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 8 '49	Benign Prostatic Hypertrophy	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/11, 1949, *to* 8/12, 1949, *that I last saw the deceased alive on* 8/12, 1949, *and that death occurred at* 12:10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. Robert Hardy M. D.	West Balt. Gen'l Hosp	8/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/15/49	Mt. Olivet	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 15 1949	Tunstall Williams, M.D.	Wm Cook Inc. 1217 St. Paul St.

VS 150

137a

correct age is especially important. Physicians: please write the

G77239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77239

BIRTH NO. 15 Registered No.

1. NAME OF DECEASED (Type or Print) Mary V. Glantz

2. DATE OF DEATH 8/12/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2824 Inglewood Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) " " "

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 17-04

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 3000 Guilford Ave

5. SEX	6. COLOR OR RACE	7. ~~SINGLE, MARRIED~~, WIDOWED, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	10/17/1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Balto. Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Randolph Archer	Avabelle Lutton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Virginia Boyd	2824 Inglewood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 14 Months

DUE TO

(B)

DUE TO

(C) Chronic myocarditis

Arteriosclerosis (generalized)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 20, 1949 *to* Aug 12, 1949 *that I last saw the deceased alive on* Aug 11, 1949 *and that death occurred at* 1:45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. V. Harbold M. D.	4706 Harford Road	8-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	8/15/49	Cedar Hill	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Wm Bok Inc	127 St. Paul St.

VS 150

46E

(7723-0)

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. BC-49-03882

CERTIFICATE OF DEATH

Registered No. (7723-0)

1. NAME OF DECEASED (Type or Print) MAX JOSEPH CARR

2. DATE OF DEATH August 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 724 S. Bond Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	S	Feb 20/49		5			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Baltimore Md	

13. FATHER'S NAME Francis Carr

14. MOTHER'S MAIDEN NAME Elaine Lockman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT Elaine Lockman ADDRESS 724 S Bond

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Status thymicolymphaticus — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
George A. Merrill M.D.		August 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 15/49	Meadowridge Mem	Elkridge Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Philip Herwig Sons, Eutaw St	3029

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AB-129701
G77241

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77241
Registered No.

1. NAME OF DECEASED (Type or Print): Rosa Davis

2. DATE OF DEATH: August 10- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 10yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 119 Hill Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Negro	Single	Dec. 5-1924	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Virginia	

13. FATHER'S NAME: John Davis

14. MOTHER'S MAIDEN NAME: Ida Lipscomb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Baltimore City Hospitals Records: ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculosis Meningitis
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Tuberculous lymphadenitis and tuberculosis of spine - Tuberculous cystitis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June 24-1949	Spinal Cord Tumor	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 6-16- , 1949, *to* 8-10- , 1949, *that I last saw the deceased alive on* 8-10- , 1949, *and that death occurred at* 9.30P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. S. Rogers M. D.	4940 Eastern Ave.	Aug. 12-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/15/49	Mt Calvary	A. A. Co., Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	D. L. Brown & Son	108 W Montgomery St

Cause age is especially important. Physicians - please write clearly.

VS 150

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G77242

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51

G77242

Registered No.

1. NAME OF DECEASED (Type or Print) JACOB FIERSUK OR JFERSUK

2. DATE OF DEATH August 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 673 W. Barre St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 673 W. Barre St. 22-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Unknown	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Russian	

13. FATHER'S NAME ? Fiersuk

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	

17. INFORMANT Mrs. Catherine Fiersuk ADDRESS 673 W. Barre

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer Stomach — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1949, *to* Aug 11, 1949, *that I last saw the deceased alive on* Aug 11, 1949, *and that death occurred at* 3:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr. Meridelis M. D.	651 N. Bentalou	8/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 15-49	Holy Redeemer	4430 Belair Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	J. A. Grebliauckas Jr.	1905 E. Pratt St

VS 150

46B

3. Johnschmidt's

G77243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 yr 1

Registered No. G77243

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Miller, William J

2. DATE OF DEATH Aug 12. 49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
West Balto. Gen. Hosp

c. Length of stay in Baltimore 37 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
3301 Wesley Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	W	July 6. 1870	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher		So Milwaukee. Wisc.	

13. FATHER'S NAME
Enoch Kempster Miller

14. MOTHER'S MAIDEN NAME
Fannie Jeffrey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Spanish Am. Serv.

16. SOCIAL SECURITY NO.

17. INFORMANT
William Kempster
ADDRESS
3301 Wesley Ave

MEDICAL CERTIFICATION

(Physicians: please write clearly and legibly. Exact age is especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO

(B) Arteriosclerotic cardiovascular disease — many years

DUE TO

(C)

ANTECEDENT CAUSES

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriosclerotic nephritis, mod. — ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-12 19 49 *to* 8-12 19 49 *that I last saw the deceased alive on* 8-12 19 49 *and that death occurred at* 11 45 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. H. Davis M. D.	West Balto. Gen Hosp	8-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 15-49	St. Mary Annes	North East Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Ellsworth Armacost 5118 Guilford Ave

VS 150

131a

G77244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 931

Registered No. G77244

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Harold Hogan, N-981.3

2. DATE OF DEATH August 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3010 Hudson St.,

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3010 Hudson St., 1-01

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH August 6, 1904

9. AGE (In years last birthday) 43 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY Meat truck

11. BIRTHPLACE (State or foreign country) Rock Hall, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Earl Hogan

14. MOTHER'S MAIDEN NAME Ada Stevens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS Mrs. Vera Hogan 3010 Hudson St.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 dy

DUE TO

(B) Heart arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/9/49 *to* 8/11/49 *that I last saw the deceased alive on* 8/10/49 *and that death occurred at* 1:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE R. Talbert Francis M. D.

23B. ADDRESS 1011 S Bond Ave

23C. DATE SIGNED 8/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Aug 15, 1949

24C. NAME OF CEMETERY OR CREMATORY Parkwood

24D. LOCATION (City, town, or county) (State) Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 15 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS Ullrich Funeral Home 2008 Orleans St.,

VS 150

191

correct age is especially important. Physician: please write the

G77245 CERTIFICATE CORRECTED 8-16-49 X ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

2040

G77245 Registered No.

BIRTH NO. B-48-04546

1. NAME OF DECEASED (Type or Print) CARL Lee HARKINS

2. DATE OF DEATH AUGUST 13, '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL

c. Length of stay in Baltimore 18 ~~Yrs.~~ Mos. ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) FULLERTON
D. STREET ADDRESS (If rural, give location) Walter Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	SINGLE	Feb 29 1948	1	6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	INFANT	MARYLAND	U.S.A.

13. FATHER'S NAME T. ALFRED HARKINS

14. MOTHER'S MAIDEN NAME ELMIRA HORN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		MOTHER	SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) LYMPHATIC LEUKEMIA — INTERVAL BETWEEN ONSET AND DEATH: 5 months
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. ~~HOW~~ DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 15, 1949 *to* August 13, 1949, *that I last saw the deceased alive on* Aug 13, 1949, *and that death occurred at* 9:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edmund B. Middleton M. D.	University Hospital	Aug 13 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	8/16/49	St. Michael's Lutheran	Perry Hall, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Lassahn Funeral Home	7401 Belair Rd.

VS 150

74a

Correct age is especially important. Physician: please write this

G77246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

G77246

Registered No.

1. NAME OF DECEASED (Type or Print): Dr. Richard Holden Follis M.D.

2. DATE OF DEATH: August 13, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1700 Park Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wheeler Nursing Home
c. Length of stay in Baltimore: 55 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 30 Whitfield Rd.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Feb. 6, 1876
9. AGE (In years last birthday): 73 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): San Francisco, Cal.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Richard H. Follis
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Dr. Richard H. Follis Jr. 3722 Linda Ann Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia
DUE TO
(B) Arteriosclerotic heart disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August, 1945 *to* Aug. 13, 1949 *that I last saw the deceased alive on* Aug 13, 1949, *and that death occurred at* 4:40 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Palmer H. Futcher M. D.
23B. ADDRESS: 3911 Canterbury Rd.
23C. DATE SIGNED: Aug. 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. 15, 1949
24C. NAME OF CEMETERY OR CREMATORY: Green Mount Cemetery
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: John Mitchell Sons 1900 Eutaw Place

VS 150

937

- Please write the cause of death clearly and legibly. Physician: please be especially careful that the correct age is especially important.

G77247 ✓ G77247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 17°

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bertha Leah Martien

2. DATE OF DEATH: August 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1700 Park Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wheeler Nursing Home
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1700 Park Ave. 14-01

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Dec. 15, 1860
9. AGE (In years last birthday): 88 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired schoolteacher
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William Martien
14. MOTHER'S MAIDEN NAME: Leah Evans
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: James Carey Martien-1813 Thornbury Road (ADDRESS)

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of breast
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Pulmonary edema

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-10, 1949, to 8-12, 1949, *that I last saw the deceased alive on* 8-12, 1949, *and that death occurred at* 4:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm. P. Benson, Jr. M. D.
23B. ADDRESS: Women's Hosp.
23C. DATE SIGNED: 8-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 8/15/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR (ADDRESS): John O. Mitchell & Sons, Inc.-1900 Eutaw Place
Mahlon B. Mitchell 50

VS 150

Please write the cause of death clearly and legibly. Physicians: please write correct age in especially important.

77248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77248

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Douglas Durrell Monroe

2. DATE OF DEATH 8/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland ✓

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.

c. Length of stay in Baltimore since 7/29/49 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE N.Y. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pelham. N.Y.

D. STREET ADDRESS (If rural, give location) 1324 Manor Circle

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Jan. 27 1900	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Executive	Oil Business	Texas	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Edward Monroe	Nettie Little

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Margaret Monroe	Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) adrenal insufficiency	
	DUE TO (B) adrenal hemorrhage	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Gastric ulcers.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/29/49 *to* 8/14/49, *that I last saw the deceased alive on* 8/14/49 *and that death occurred at* 6:00 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles N. Watt, Jr. M.D.	Union Memorial Hospital	8/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 18, 1949		Beaumont, Texas

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Hunter Lee Williams, M.D.	John O. Mitchell Sons	1900 Eutaw Place

VS 150

6513

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BIRTH NO. G77249

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77249

1. NAME OF DECEASED (Type or Print): Thomas Munroe

2. DATE OF DEATH: August 12-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 324 E. 25th. St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Widowed	Nov. 11-1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME: (D

14. MOTHER'S MAIDEN NAME: (D

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT'S ADDRESS: Baltimore City Hospitals Records-4940 Eastern Ave.

MEDICAL CERTIFICATION

(Please write the cause of death clearly and accurately. Physician: please write the correct age is especially important.)

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia and possible fat embolism
DUE TO
ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Sub-Capital Fracture right Femur

INTERVAL BETWEEN ONSET AND DEATH:

CERTIFICATION APPROVED BY
Dr. Chester J. Lubinski
per: H. J. McClafferty M.D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Home -outside	On steps and fell on pavement

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 27-1949 m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Tripped on a step while carrying some packages

22. *I hereby certify that I attended the deceased from* 7-27, 1949 *to* 8-12-, 1949, *that I last saw the deceased alive on* 8-12-, 1949, *and that death occurred at* 3.45P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. S. Rogers M. D.	Baltimore City Hospitals	August 13-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	8/15/49	Concelman Bros	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Tomlinson Williams, M.D.	William C. Dru	1911 E. Lanvale

VS 150

To be approved by the Medical Examiner

186a

G77250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77250

BIRTH NO.

1. NAME OF DECEASED (Type or Print) IGNATIUS (IGNACY) WISNIEWSKI

2. DATE OF DEATH August 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 237 South Washington Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widowed	Jan. 18, 1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown		Polant	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Anna Kaczynski	1234 St. Ellwood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE George L. Wheeler M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED August 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	Aug. 16, 1949	St. Stanislaus Cemetery	Dundalk Ave., Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	John J. Dudo	935

VS 151

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G77251

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

581.0

G77251

Registered No.

1. NAME OF DECEASED (Type or Print) JOHN A PANUSKA

2. DATE OF DEATH 8-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 2340 E. Eager St. 7-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Aug. 29-1903	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
City Policeman		Balto. Md.	

13. FATHER'S NAME Edward Panuska

14. MOTHER'S MAIDEN NAME Margaret Hildebrandt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Emma Goetze	2340 E. Eager St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.)

(A) BLEEDING ESOPHAGEAL Varices

DUE TO

(B) PORTAL CIRRHOSIS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-5 1949 *to* 8-13 1949, *that I last saw the deceased alive on* 8-13 1949, *and that death occurred at* 930 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. Kott M. D.	Sinai Hosp.	8-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 16-49	Balto. Cemetery	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Remington for Williams, M.D.	John A. Miller	2334 Jefferson St.

VS 150

124B

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77252

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Elizabeth Shanahan

2. DATE OF DEATH: 8/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 802 Reservoir St

c. Length of stay in Baltimore: 87 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 802 Reservoir St. 13-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	single	1-12-62	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Shanahan

14. MOTHER'S MAIDEN NAME: Mary Kennedy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dorothy Dungison ADDRESS: 802 Reservoir

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 18 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-6-49 *to* 8/12/49, *that I last saw the deceased alive on* 8/12/49, *and that death occurred at* 1.55 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John F. Schaefer M. D.

23B. ADDRESS: 2128 St. Paul St.

23C. DATE SIGNED: 8/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 8-16-49

24C. NAME OF CEMETERY OR CREMATORY: Western Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. J. Tucker & Son ADDRESS: Balto., Md.

VS 150

937

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G77253

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77253

1. NAME OF DECEASED (Type or Print): MARY McPHERSON WICKLIFFE

2. DATE OF DEATH: Aug. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4241 Wickford Rd.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4241 Wickford Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
female	white	widow	3/12/1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Louisville, Ky.	

13. FATHER'S NAME: Simon McPherson

14. MOTHER'S MAIDEN NAME: Clara Clarke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Miss Jean Wickliffe	4241 Wickford Rd.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of liver — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT:

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June 27 1949	Adenocarcinoma of liver	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 26, 1949, *to* Aug 12, 1949, *that I last saw the deceased alive on* Aug 12, 1949, *and that death occurred at* 5 50 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William E. Gilmore M. D.	100 E. 33rd St. Baltimore Md	Aug 13 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	8/16/49	Arlington National Cem	Arlington, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, MD	WM. J. TICKNER & SONS	Balto., Md.

VS 150

46 F.

G77254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77254

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CARL H. MEYER

2. DATE OF DEATH: Aug. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1520 E. 33rd St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1520 E. 33rd St. 9-0

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Mar. 13, 1886
9. AGE (In years last birthday): 63 yrs.
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician
10B. KIND OF BUSINESS OR INDUSTRY: Own Practice
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Dr. Charles Meyer
14. MOTHER'S MAIDEN NAME: Charlotte Lipp
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Hannah Meyer ADDRESS: 1520 E. 33rd St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of liver, metastatic — INTERVAL BETWEEN ONSET AND DEATH: 4 mo.
DUE TO
(B) Carcinoma of Cecum — 1 yr
DUE TO
(C) —

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Feb. 1948
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Cecum
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* Feb 1948 *to* Aug 11 1949, *that I last saw the deceased alive on* Aug 11, 1949, *and that death occurred at* 10 20/60 *m., from the causes and on the date stated above.*

23A. SIGNATURE: J. Whisworth M. D.
23B. ADDRESS: 1129 St Paul St
23C. DATE SIGNED: 8/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/15/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

46E

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G77255 ✓ 44 G77255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Arthur Thompson

2. DATE OF DEATH: 8-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1017 Rice St

c. Length of stay in Baltimore: 29 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1017 Rice St 16-01

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 4-19-1901
9. AGE (In years last birthday): 48 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Asheville N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 212-05-5124

17. INFORMANT: Ora Thompson ADDRESS: 834 N. Fayette

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician: please write exact age if especially important.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema
DUE TO
(B) Hypertensive C-V Renal. Dis. c Myocardial Failure
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 5 days
(B) ?
(C)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/8 1949 to 8/13 1949 that I last saw the deceased alive on 8/8 1949, and that death occurred at 2 PM m., from the causes and on the date stated above.

23A. SIGNATURE: J. Preston Grant M. D.
23B. ADDRESS: 601 N. Carrollton
23C. DATE SIGNED: 8/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): B.
24B. DATE: 8-16-49
24C. NAME OF CEMETERY OR CREMATORY: Western Star
24D. LOCATION (City, town, or county) (State): Catonsville Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Samuel W. Sullivan Jr. ADDRESS: 1311a 1011 N. Arlington Ave

VS 150

G77256

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77256

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Leroy Frazier

2. DATE OF DEATH: August 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Randallstown
D. STREET ADDRESS (If rural, give location): Liberty Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 11, 1891
9. AGE (In years last birthday): 58 yrs
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10B. KIND OF BUSINESS OR INDUSTRY: Contractors
11. BIRTHPLACE (State or foreign country): Baltimore County, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William W. Frazier
14. MOTHER'S MAIDEN NAME: Hester Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-10-0379
17. INFORMANT: Mrs. Hester Walters, Liberty Rd. ADDRESS Randallstown, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pulmonary edema due to acute alcoholism

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 14 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. 15, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cemetery
24D. LOCATION (City, town, or county) (State): Randallstown, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: E. W. Lamoreau
ADDRESS: 4510 Liberty Heights Ave.

VS 151

77c

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G77257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57 1.0

Registered No. G77257

BIRTH NO B.C. 48-01066

1. NAME OF DECEASED (Type or Print) ODOMS, DONALD

2. DATE OF DEATH 8-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp., Balto, md.

c. Length of stay in Baltimore 18 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto, Md.
D. STREET ADDRESS (If rural, give location) 928 Argyle Ave 17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	S	January 12, 1948	1	18 7	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Paul Odoms

14. MOTHER'S MAIDEN NAME Evelyn Buck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Paul Odoms 928 Argyle Ave

MEDICAL CERTIFICATION

(Correct age is especially important. Physician: please write the cause of death clearly and legibly.)

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dehydration & Acidosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Vomiting & diarrhea — 1 day.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia; aspiration

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 12, 1949 to ____, 19__, *that I last saw the deceased alive on* Aug 12, 1949. *and that death occurred at* 12:30 Am., *from the causes and on the date stated above.*

23A. SIGNATURE Garrett E Deane M. D.

23B. ADDRESS Balto md. Univ Hosp

23C. DATE SIGNED 8-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE August 15, 1949

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 15 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Mrs Katie R. Williams

ADDRESS 522 N Schroeder St

VS 150

119a

G77258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1949

G77258

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): VINCENT J. SERIO

2. DATE OF DEATH: AUGUST 13 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2106 ALLENDALE RD
C. Length of stay in Baltimore: 35 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2106 ALLENDALE RD. 15-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	MAY 14 1900	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRINTER
10B. KIND OF BUSINESS OR INDUSTRY: MD PAPER BOX CO

11. BIRTHPLACE (State or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH SERIO

14. MOTHER'S MAIDEN NAME: ROSE DEMARCO

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: MARY D SERIO ADDRESS: 2106 ALLENDALE RD.

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.)

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Metastatic Carcinoma of lungs bilateral; skull and spine — INTERVAL BETWEEN ONSET AND DEATH: 9½ mos.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8 June 1949 to 13 Aug. 1949 *that I last saw the deceased alive on* 13 Aug 1949 *and that death occurred at* 2.45 *a. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Michael L. De Vincentis M. D.	11 E. Chase St	13 Aug 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	AUG 16 1949	NEW CATHEDRAL	OLD FREDERICK RD MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Doffel Bro	1800 E LOMBARD ST.

VS 150

47D

G77259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4700 G77259

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John Frank Killian

2. DATE OF DEATH Aug. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR ~~XXXXXXXXX~~ (If not in hospital or institution, give street address or location) St. Joseph's
c. Length of stay in Baltimore 63 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4008 Fleetwood Ave. 27-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	Widowed	June 25 1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Store Keeper	Europe Bohemia	U S A

13. FATHER'S NAME John Killian

14. MOTHER'S MAIDEN NAME Katherine Conrad

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	----	None	William F. Killian	4008 Fleetwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 12, , 1949, *to* Aug. 14, , 1949 *that I last saw the deceased alive on* Aug. 14, , 1949 *and that death occurred at* 3:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. H. Kaan M. D.	1400 N. Caroline St.	Aug. 14, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 17 1949	Holy Redeemer	4430 Belair Rd Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Duffel Bros	7110 Belair Rd.

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

93

G77260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1561 G77260 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Herbert Mitchell

2. DATE OF DEATH: Aug. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gardenville Nursing Home 7440 Belair Road

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived if institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sparrows Point
D. STREET ADDRESS (If rural, give location): 715 E. Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	M	Aug. 18, 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10B. KIND OF BUSINESS OR INDUSTRY: Beth. Steel Co.
11. BIRTHPLACE (State or foreign country): Chester, Pa.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Emanuel Mitchell
14. MOTHER'S MAIDEN NAME: Hanna Whittaker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Herbert Mitchell, Sparrows Pt. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of liver
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST."

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Benign prostatic hypertrophy
Chronic myocarditis

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 8, 1949 to Aug 13, 1949 that I last saw the deceased alive on Aug 11, 1949 and that death occurred at 8 A m., from the causes and on the date stated above.

23A. SIGNATURE: H. V. Hartsock M. D.
23B. ADDRESS: 4706 Harford Road
23C. DATE SIGNED: Aug. 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. 16 1949
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): 4225 Eastern Blvd ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Roland L. Fisher 2112 Dundalk ave.

VS 150

46F

G77261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

350

Registered No. G77261

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harriet Elizabeth Neale

2. DATE OF DEATH: Aug. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Buchhill Nursing Home 6028 Old Harford Road

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): Old Battle Grove

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: July 14, 1875
9. AGE (In years last birthday): 74
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ethel Smith, 6925 Ridgeway ADDRESS Dundalk Md

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
ANTECEDENT CAUSES
(B) Paralysis Agitans — 3 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 August, 1949 to 14 Aug., 1949, that I last saw the deceased alive on 13 Aug, 1949, and that death occurred at 10:25 A m., from the causes and on the date stated above.

23A. SIGNATURE: Roy W. Zimmerman M. D.
23B. ADDRESS: 2058 Harford Rd.
23C. DATE SIGNED: 15 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 16, 1949
24C. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery
24D. LOCATION (City, town, or county) (State): Chase, Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Beatrice for Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Roland L. Fisher, 2112 Dundalk Ave.

VS 150

87c

Physician: please write the cause of death clearly and legibly. Please write the cause of death clearly and legibly.

G77262

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 1 G77262 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE J. BORY

2. DATE OF DEATH August 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1647 Darley Avenue 8-05

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Nov.27, 1895
9. AGE (In years last birthday): 53 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crain Operator
10B. KIND OF BUSINESS OR INDUSTRY: Con. Gas & Elec. Co.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: George Bory
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Mrs. Viola A. Bory - 1647 Darley Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease
DUE TO
(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 8/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/16/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Eastern Ave. Rd., Balto.Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Beatrice Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 151

94a

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G77263

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

154 G77263 Registered No.

1. NAME OF DECEASED (Type or Print) LENA AIELLO

2. DATE OF DEATH 17 August 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

C. Length of stay in Baltimore 35 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 213 N. KENWOOD AVE 6-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	MARRIED	8/21/1899	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWORK	HOME	ITALY	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DOMINIC PROFILI	Angela Marengo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		Mary Moore,	213 N. Kenwood Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of Rectum	10 Months
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9 NOV 1948	ADENOCARCINOMA Rectum & METASTASIS	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Aug 12, 1949, *to* Aug 14, 1949, *that I last saw the deceased alive on* Aug 14, 1949, *and that death occurred at* 1:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John M. Blessum Jr M. D.	Sinai Hospital	Aug 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/18/49	Holy Redeemer Cemetery	4430 Belair Rd. Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR. ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

Please write plainly; use ink. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

467

G77264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 1.14:3

Registered No. G77264

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HENRY SCHLOTMAN — N-948

2. DATE OF DEATH 8/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore: 20 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: ----------
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 802 West Lombard St. 18-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	--------	About 44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker

10B. KIND OF BUSINESS OR INDUSTRY: --------

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? -----

13. FATHER'S NAME: Clemens Schlotmann

14. MOTHER'S MAIDEN NAME: Anna von Dornick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ------

(If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: ----------

17. INFORMANT: Anton Schlotmann ADDRESS: 1224 Maiden Choice Rd. Arbutus

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Electrocution — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Bakery

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 803 West Lombard Street 18/3

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 8 13 49 10:30 a.m.

21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? Brought left arm to 110 Volt wire while repairing electric baker's oven

22. *I certify that I took charge of the remains described above, held an* Inspection Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: John R. Davis, M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: 8/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/16/49	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: H. H. Mears and Son 805 N. Calvert St.

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VS 151

Please write clearly and with ink; print the cause of death clearly and legibly. Physician: please write exact age is especially important.

G77265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

924.0 G77265 E

Registered No.

BIRTH NO B.C.48-2015

1. NAME OF DECEASED (Type or Print) LEON NICK — N-9.91

2. DATE OF DEATH August 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore Life — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 510 Oxford Street 17-a-v

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	colored	Child	Aug. 29, 1948		11	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child		Baltimore, Md.	

13. FATHER'S NAME Earl Thomas Nick Jr.

14. MOTHER'S MAIDEN NAME Mary Francis Dyson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mary Dyson - 510 Oxford St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mechanical suffocation

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	510 Oxford Street 17/2

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 10, 1949 ? m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Suffocated by bedclothes

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER [X] / MEDICAL INVESTIGATOR	23C. DATE SIGNED
George G. Merrill M.D.		August 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/15/49	Mt. Calvary	Cedar Hill Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	A. Halstead - 98	Druid Hill Ave

VS 151

182a

G77266 ✓ G77266

G77266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): PETER TAYLOR

2. DATE OF DEATH: August 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1154 N. Mount Street 16-03

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 11/2/1894
9. AGE (In years last birthday): 54
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): King Wms. Co. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel Bass
14. MOTHER'S MAIDEN NAME: Rebecca Taylor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): W. (If yes, give war or dates of service): W. D.
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Taylor ADDRESS 1381 Woodyear St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic myocardial degeneration	
ANTECEDENT CAUSES	DUE TO (B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Emil L. Roy M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 8-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/15/49
24C. NAME OF CEMETERY OR CREMATORY: Balto. National
24D. LOCATION (City, town, or county) (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Geo. G. Kelon 1303 Pressman St.

935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. If unknown, write "unknown." Do not abbreviate. Use no ditto marks. Where no entry is necessary, write "none." Where exact date of death is unknown, state approximate date if possible. Where exact age is especially important, please write the cause of death clearly and legibly.

G77267 G77267

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 99

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Walter A. Coppinger
2. DATE OF DEATH 8-11-49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
C. Length of stay in Baltimore 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 819 Beaumont 27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, (MARRIED) WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W			75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter		Ireland	U

13. FATHER'S NAME: John Coppinger
14. MOTHER'S MAIDEN NAME: Mary Tansey MULREY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Walter P Coppinger ADDRESS: 8534 Locust Hill Rd. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Hemorrhages — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Blood Dyscrasia
DUE TO
(C) Type undetermined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION.	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-1-49	Sternal bone button	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Workshop - School	Loyola High school

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
7-24-49 m.	WHILE AT WORK [X] NOT WHILE AT WORK [ ]	Disease brought to attention by bleeding of fingers

22. *I hereby certify that I attended the deceased from* 7-26-49 19__, *to* 8-11 19 49, *that I last saw the deceased alive on* 8-01 19 49 *and that death occurred at* 11:59 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	Mercy Hosp	8-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/16/49	Cathedral	Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Thurlow Williams, M.D.	J. Baker Sons	1318 Light St

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Enter the cause of death clearly and legibly. Exact age is especially important. Physicians: please write the

129

G77268

G77268

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SUSAN RENEHAN

2. DATE OF DEATH Aug. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Mercy Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL

c. Length of stay in Baltimore 3 DAYS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived, not where died)
A. STATE MARYLAND B. COUNTY Ellicott City Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ellicott City
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	Widowed	APR 1 1869	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Maryland	U.S.

13. FATHER'S NAME Henry Denneade

14. MOTHER'S MAIDEN NAME Mary Lyddon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		—	Mary Klein	Ellicott City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Hypertension Cardiovascular Renal

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 9, 1949 *to* Aug 12, 1949, *that I last saw the deceased alive on* Aug 12, 1949, *and that death occurred at* 10:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mary E. Mathes M. D.	Mercy Hospital	Aug 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 16 1949	St Louis	Clarksville Howard Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Hunterstone Williams, M.D.	F.C. Higinbotham	Ellicott City Md

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if known. Do not write the cause of death clearly and legibly. correct age is especially important. Physician: please write

G77269 ✓ 4 G77269

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. Give correct age in years, months, days or hours, whichever is especially important.

MEDICAL CERTIFICATION

1. NAME OF DECEASED (Type or Print): SAMUEL ROGERS — 2. DATE OF DEATH: August 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellicott City
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	7-14-1883	66	1 / 0	0 /

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	—	Howard County	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel D Rogers	Mary Osborne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
?		?	Caleb D. Rogers	Ellicott City

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Broncho pneumonia	
DUE TO	(B) Fracture, legs & Lft arm	
DUE TO	(C)	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	street	Route #1, Savage, Howard Co., Maryland

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21F. HOW DID INJURY OCCUR?
July 22, 1949 9:10 P m.		Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X] suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
W. J. McClafferty M.D.	[ ] / [X] / [ ]	8-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 16-1949	St Johns	Ellicott City Howard Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	H. C. Higinbotham,	Ellicott City Md

VS 151

170c ✓

G77270

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4/50.0

G77270

Registered No.

1. NAME OF DECEASED (Type or Print): Anna Lee Callaghan

2. DATE OF DEATH: August 13th 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3621 Forest Park Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3621 Forest Park Avenue

1 J 38

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widowed	January 24th 1860	89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Westminster, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Sheets	Marie Krause

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	Mrs Wilbur Coyle, Jr. 3621 Forest Park Aven

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.)

(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 dys

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Bronchopneumonia — 12 dys

DUE TO

(C) Arteriosclerosis — 10 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral Arteriosclerosis — 5 yrs

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 2, 1949, *to* August 10, 1949, *that I last saw the deceased alive on* Aug 16, 1949, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	3403 Garrison Blvd.	August 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	August 17-1949	Westminster	Carroll County, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Wm. J. Tickner & Sons, North & Penna. Aves.

VS 150

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered carefully and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G77271

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

49-1 G77271 Registered No.

1. NAME OF DECEASED (Type or Print) CHRISTINE GROTHAUS

2. DATE OF DEATH 8-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hosp. For The Women of Maryland
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-07
D. STREET ADDRESS (If rural, give location) 3215 ~~St~~. Charles St. (Rochester apts.)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	April 30, 1886	63	3 / 14	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Office
10B. KIND OF BUSINESS OR INDUSTRY Clerk
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Grothaus
14. MOTHER'S MAIDEN NAME Mary ~~Ann~~ RICHTER Grothaus
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ?
17. INFORMANT Patient ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be completed. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Retroperitoneal Sarcoma
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-9, 1949 *to* 8-14, 1949, *that I last saw the deceased alive on* 8-14, 1949, *and that death occurred at* 2:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE Wm. P. Benson, Jr. M. D.
23B. ADDRESS Women's Hosp.
23C. DATE SIGNED 8-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/17/49
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 15 1949
REGISTRAR'S SIGNATURE Remington Williams, M.D.
25. FUNERAL DIRECTOR WM. J. TICHNER & SONS INC.
ADDRESS North & Pa. Ave. Baltimore 17, Md.

VS 150

46H

G77272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77272

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM C. MORGAN

2. DATE OF DEATH Aug. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 14 E. 22nd St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 14 E. 22nd St. 12-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months / Days	If Under 24 Hours Hours / Min.
M	W	Single	Oct. 17, 1872	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	--	Clarke Co. Va.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm. C. Morgan	Sarah Sheppard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		?	Miss Sarah E. Morgan	14 E. 22nd St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Cerebral Hemorrhage, Generalized arteriosclerotic, Hypertensive Cardio-Vascular disease — 12 Wks/weeks

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August 1, 1949, *to* August 15, 1949, *that I last saw the deceased alive on* Aug 14, 1949, *and that death occurred at* 3:20 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Newland Edward Day M. D.	4-E-33rd St - 18	Aug. 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	8/16/49	Berryville, Va. (Greenhill)	Berryville, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Wm. J. Tickner & Sons,	North & Penna. Aves

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if possible. Please write the cause of death clearly and correct age is especially important. Physician: please write legibly.

77273

CERTIFICATE CORRECTED ✓ 11-2-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

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77273

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Dora Margaret Wawrzyniak

2. DATE OF DEATH August 11th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1654 E.25th St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1654 E.25th St. 8-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Jan. 29 1915	34	6 / 14	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Baltimore Md.	

13. FATHER'S NAME: Vincent Ingrassia

14. MOTHER'S MAIDEN NAME: Santa Culotta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Carl Wawrzyniak	1654 E.25th St.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as correctly and completely as possible. Write the cause of death clearly and legibly. Physician: please write the correct age if especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 1942
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947 to 8/11/49, 19__, that I last saw the deceased alive on 7/17 1949 and that death occurred at ____ m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lawrence M. Stern M. D.	11 E. Chase St	8/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 16 1949	Holy Redeemer Cem.	4430 Belair Rd. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Frank Della Vecchia	322 S. High St.

VS 150

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G77274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77274

BIRTH NO.

1. NAME OF DECEASED (Type or Print) KATHERINE HOMMERBOCKER

2. DATE OF DEATH Aug 12-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1225 Hollins St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

c. Length of stay in Baltimore 85- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1225 Hollins St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Female	white	Widow	May ? 1864	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at Home	Baltimore, Md	

13. FATHER'S NAME Patrick McMahon

14. MOTHER'S MAIDEN NAME Mary Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT Mrs Dewey Warehime ADDRESS 1225 Hollins St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Generalized Arteriosclerosis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug , 1947, *to* Aug 12, 1949, *that I last saw the deceased alive on* Aug 12, 1949, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Morris B. Schreiber M. D.	5 W. Fulton Ave	8-15-'49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 16/49	New Cathedral Cem	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Geo. L. Berger Jr	1512 Hollins St

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Be sure the information furnished is correct and complete. Physician: please write the cause of death clearly and legibly. age is especially important.

AB-129363

G77275

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77275

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use no abbreviations. Be correct age is especially important. Physician: please write the cause of death clearly and fully.

1. NAME OF DECEASED (Type or Print): Grace Allocca

2. DATE OF DEATH: August 11-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3613 Hickory Ave. 13-06

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 15-1922
9. AGE (In years last birthday): 27 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Ivan Taylor
14. MOTHER'S MAIDEN NAME: Anna Heuer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals ADDRESS: Records: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Post operative shock
DUE TO (Pneumonectomy)
(B) Pulmonary tuberculosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: over

19A. DATE OF OPERATION: August 11-1949
19B. MAJOR FINDINGS OF OPERATION: Left Lobectomy
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-2- , 1949 *to* 8-11- , 1949 *that I last saw the deceased alive on* 8-11- , 1949 *and that death occurred at* 5.20 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: A. S. Aegon M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: Aug. 11-1949

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 8/15/49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Memorial
24D. LOCATION (City, town, or county) (State): City

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WIEDEFELD & SON
ADDRESS: GREENMOUNT AVE & 22ND

VS 150

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677276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. 677276

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mamie John

2. DATE OF DEATH Aug. 14th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 315 S. Conkling Str.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 315 S. Conkling Str. 26-08

5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH Dec. 7th 1876
9. AGE (In years last birthday) 72
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Balto., Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Martin J. Reese
14. MOTHER'S MAIDEN NAME Catherine Pfrom

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Pauline Berlett - Same as above ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
DUE TO
(B) Hypertension
DUE TO
(C) Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 4 W/s.
(B)
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-17 19 49 *to* 8-14 19 49 *that I last saw the deceased alive on* 8-14 19 49 *and that death occurred at* 6 23 *m., from the causes and on the date stated above.*

23A. SIGNATURE Victor J. Monfeld M. D.
23B. ADDRESS 540 Belair Rd.
23C. DATE SIGNED 8-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug. 17-49
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 15 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR John J. Connelly ADDRESS 418 Eastern Ave. Balto., 21, Md.

VS. 150

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered correctly and completely. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G77277

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

99-7

Registered No. G77277

1. NAME OF DECEASED (Type or Print) MICHAEL J. COFFAY (MICHAEL JOSEPH COFFAY) 2. DATE OF DEATH 8-13-49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSP.
C. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1354 CROFTON Rd. 27-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	WIDOWED	APR. [illegible], 1873	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED CARPENTER		MARYLAND	U.S.A.

13. FATHER'S NAME WILLIAM COFFAY

14. MOTHER'S MAIDEN NAME MARY DOHERTY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		MRS. ERIC HENDERSON MRS. EDWIN WRIGHT	1354 CROFTON RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARCINOMATOSIS
DUE TO
(B) ORIGIN UNKNOWN.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 9 wks.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-1-49	CARCINOMATOSIS IN ABDOMIN	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-1, 1949, *to* 8-13, 1949, *that I last saw the deceased alive on* 8-12, 1949, *and that death occurred at* 12:50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. C. Martin M.D. M. D.	Maryland General Hospital	8-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	8/16/49	Parkwood Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
AUG 15 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC BALTIMORE - 13, MARYLAND

VS 150

55E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physician please write the cause of death clearly and legibly.

G77278 Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77278

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby "Boy" Dawson

2. DATE OF DEATH: JUL 22 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5 North Point Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		7-22-49			2/2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Harry Dawson

14. MOTHER'S MAIDEN NAME: Dorothy ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis, congenital
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-22- 1949 *to* 7-22- 1949, *that I last saw the deceased alive on* 7-22 1949, *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: William W. Canine M. D. | 23B. ADDRESS: JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED: 7-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet | 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1 5 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR | ADDRESS

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physician: please write the cause of death clearly and legibly.

159

G77279A

A71955

G77279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C.49-16076 — Registered No. 1605

1. NAME OF DECEASED (Type or Print): Baby Norton

2. DATE OF DEATH: Aug. 3, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25
D. STREET ADDRESS (If rural, give location): 2827 Russell St. 3

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 7-3-49
9. AGE (In years last birthday) — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.: 1 day
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Benjamin Norton
14. MOTHER'S MAIDEN NAME: Colleen ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intracranial hemorrhage
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 8/3, 1949, *to* 8/3, 1949, *that I last saw the deceased alive on* 8/3, 1949 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE: William W Wanny M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 8-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Hospital Disposal
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Hunting for Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS

VS 150

(Hosp, Hosp Disposal)

160a

G77280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 8 12 4

G77280

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM H. BROWN

N. 8 27. 2

2. DATE OF DEATH August 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospital

c. Length of stay in Baltimore — Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1112 S. Bonsal Street 26-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	signle	Sept. 26, 1883	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Baltimore, Maryland	

13. FATHER'S NAME: John Brown

14. MOTHER'S MAIDEN NAME: Alverta Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	none

17. INFORMANT: William Laukeman — ADDRESS: 1112 S. Bonsal Stree

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Compound fracture, left leg

DUE TO

(B) Fracture right leg.

DUE TO

(C) Retroperitoneal Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 5500 block of O'Donald Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): August 14, 1949 6.30 p.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Pedestrian struck by auto 26/5

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: W. J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR

23C. DATE SIGNED: August 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 17, 1949	Mt. Carmel Cemetery	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Philip Herwig & Sons, 2024 Orleans St.

VS 151

170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77481

Reserve #9

E 929.8 G77281

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) UNKNOWN — N-990

2. DATE OF DEATH July 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Found: E.Falls St. and Eastern Ave.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE UNKNOWN
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) UNKNOWN
D. STREET ADDRESS (If rural, give location) UNKNOWN — 3-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		/	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Drowning
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) HARBOR
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) E. Falls St. and Eastern Ave. 3/2
FOUND drowned
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) July 19 1949 ? ? m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Found drowned

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [X].*

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED 7/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY PUBLIC CEMETERY
24D. LOCATION (City, town, or county) (State) AUG 1 2 1949
25. FUNERAL DIRECTOR
ADDRESS

DATE RECEIVED BY AUG 15 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
Commissioner of Health

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and forcibly.

VS 151

183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G77282 — Registered No. G77282

1. NAME OF DECEASED (Type or Print): Eugenia Jennie Foote

2. DATE OF DEATH: Aug. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4717 Falls Road

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-14
D. STREET ADDRESS (If rural, give location): 4717 Falls Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	married	Feb. 12, 1881	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore Md.	

13. FATHER'S NAME: John Preston

14. MOTHER'S MAIDEN NAME: Mary T. Preston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Edward S. Foote — ADDRESS: 4717 Falls Rd.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. Be sure age is especially important.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 9

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B)
DUE TO (C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — Aug 12 49 4:30 p.m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May-1- 1949, to Aug 12, 1949, that I last saw the deceased alive on Aug-12, 1949 and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE: [signature] M. D. — 23B. ADDRESS: 1413 Druid Hill Ave — 23C. DATE SIGNED: Aug 15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 16/49	Arbutus Memorial Park	Arbutus Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949 — VS 150

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. H. & C. Elliott — ADDRESS: 1099 Cathedral

131a

G77283 ✓ G77283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George Parker

2. DATE OF DEATH 8/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1809 N. Mount St

c. Length of stay in Baltimore ×5 → Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 15-01
D. STREET ADDRESS (If rural, give location) 1809 Mount St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	Colored	Married	11/25/86	62 63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur	Dairy	Howard Co. Md.	U.S.

13. FATHER'S NAME. Dennis Parker.

14. MOTHER'S MAIDEN NAME Minnie Randall.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	216-10-8787	Mrs Carrie Dorsey	1809 Mount St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Disease

DUE TO

(B) Cerebral Hemorrhage

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
10 yrs.
1 wk.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 15, 1947 *to* Aug 13, 1949, *that I last saw the deceased alive on* Aug 13, 1949, *and that death occurred at* 4:30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. William Frey M. D.	1938 Penna Ave	8/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	Aug 16 1949	Mt. Lion	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 15 1949	Huntington Williams, M.D.	Geo. A. Kelson	1303 Eutaw St.

VS 150

931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

G77284

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77284

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

1. NAME OF DECEASED (Type or Print) DONALD M. GRIFFITH

2. DATE OF DEATH 8/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.
c. Length of stay in Baltimore Yrs. Mos. Days 4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Randalstown
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Child	1941 - Dec. 19	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child		Md.	U.S.A.

13. FATHER'S NAME Charles H. Griffith

14. MOTHER'S MAIDEN NAME Anna Malone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mother	

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory obstruction

DUE TO

(B) Tetanus

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ? ?

CERTIFICATION APPROVED BY [signature] M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Farm	Randalstown, Maryland

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
approx. Aug. 1, 1949 m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Stepped on something in yard and cut foot

22. *I hereby certify that I attended the deceased from* 8/9, 1949, *to* 8/15, 1949, *that I last saw the deceased alive on* 8/15, 1949 *and that death occurred at* 1:25 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nicholas Malkin M. D.	University Hosp	8/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 17, 1949	Mt. Olive	Randallstown, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williams, M.D.	C. Harry Weer	Sykesville, Md.

VS 150

To be [illegible] Medical Examiner 12

G77285

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 8-3-4 G77285

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Charles Morrison — N-803-0

2. DATE OF DEATH: August 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6547 Parnel Ave. 26-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	May 26, 1932	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alexander Morrison
14. MOTHER'S MAIDEN NAME: Maggie Swingle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None

17. INFORMANT: Alexander Morrison ADDRESS: 6547 Parnel Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture skull
DUE TO
(B) Sub arachnoid Hemorrhage
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY: (e. g., In or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Balto. Co. Greenspring & Pofton Aves. Rehtertown
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): August 15, 1949 1 A
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? turned over twice Auto ran off of road into field and /

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: William J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: August 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/16/49
24C. NAME OF CEMETERY OR CREMATORY: Moscow
24D. LOCATION (City, town, or county) (State): Moscow, Va

DATE RECEIVED BY LOCAL REGISTRAR: AUG 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilson & Son
ADDRESS: 2144 Pod St

VS 151

171 C

G77286

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77286

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) CARSON N. FRETWELL

2. DATE OF DEATH Aug. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 N. Poppleton St.
c. Length of stay in Baltimore 30 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4 N. Poppleton St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	July 12, 1870	79				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer, retired Clothing Cutter	MFG.	Virginia	

13. FATHER'S NAME James Fretwell

14. MOTHER'S MAIDEN NAME Annie M. Monroe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Noley Reid	4 N. Poppleton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized arteriosclerosis — ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 15, 1949, to August 14, 1949, *that I last saw the deceased alive on* August 13, 1949, *and that death occurred at* 6:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathan Raemin M. D.	206 S. Gilmor St.	8-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/16/49	St. Peters	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Thurston Norton Williams, M.D.	William Cook, Inc.	1217 St. Paul St.

VS 150

93D

G77287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77287

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROLAND S.T.Osbon

2. DATE OF DEATH Aug.15,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 780 Linnard St.

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 780 Linnard St. 16-08

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct.16,1881
9. AGE (In years last birthday): 67 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman, retired
10B. KIND OF BUSINESS OR INDUSTRY: Hats
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John R. Osbon
14. MOTHER'S MAIDEN NAME: Mary Shuman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Cora M. Osbon, ADDRESS: 780 Linnard St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) MULTIPLE SCLEROSIS — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 15, 1949 *to* August 15 1949, *that I last saw the deceased alive on* August 13, 1949, *and that death occurred at* 2 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Norman R. Kleiman M. D.
23B. ADDRESS: 3803 Edmondson Ave
23C. DATE SIGNED: 8/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/17/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William Cook, Inc., ADDRESS: 1217 St. Paul St.

VS 150

87D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77288

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN J. MAGILL

2. DATE OF DEATH Aug. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3027 Eastern Ave.

C. Length of stay in Baltimore — Yrs. / Mos. / Days: Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3027 Eastern Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	June 9, 1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Police Officer, retired	City of Baltimore	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Francis Magill	Margaret L. Eagan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Fred Magill	3027 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSETS AND DEATH: 2 months

DUE TO

(B) Arteriosclerosis, Generalized — 5 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 30, 1949, *to* Aug. 13, 1949, *that I last saw the deceased alive on* Aug. 12, 1949, *and that death occurred at* 5:50 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Clarence W. LeGoy, M. D. | 23B. ADDRESS: 3023 Eastern Ave. | 23C. DATE SIGNED: 8/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/17/49	Moreland Park	Baltimore County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 16 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR | ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

G77289

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77289 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JULIA S. BUTTERWORTH

2. DATE OF DEATH Aug. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 109 S. Poppleton St.

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 109 S. Poppleton St. 18-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widow	Apr. 9, 1865	84				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	

13. FATHER'S NAME: Thomas Phillips

14. MOTHER'S MAIDEN NAME: Susan Crouch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Mrs Mary L. Brant	Middle River, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C.V.D. hemorrhage
DUE TO
ANTECEDENT CAUSES
(B) Prost. carcinoma [redacted]
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: years about / wks

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 30, 1949 *to* Aug 14, 1949, *that I last saw the deceased alive on* Aug 13, 1949 *and that death occurred at* 10A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[illegible] M. D.	888 W. Lombard St	8-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/17/49	Baltimore	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	[illegible] Williams, M.D.	William Cook, Inc.,	1217 St. Paul St.

VS 150

93D

G77290 J1- 120816 ✓491 6-03 G77290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Karaban or Mary Karabin

2. DATE OF DEATH 8-15-49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 130 N. Madeira St. 6-03

5. SEX F
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Wid.
8. DATE OF BIRTH Aug. 8, 1882 ?
9. AGE (In years last birthday) 67 ? (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ? John Meast
14. MOTHER'S MAIDEN NAME ? Mary Unknown ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT B. C. H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO
(B) ~~Multi pulmonary infarctions~~ →
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Infarction of right Kidney-calcific Aortic disease

INTERVAL BETWEEN ONSET AND DEATH (over)

19A. DATE OF OPERATION 8-12-49
19B. MAJOR FINDINGS OF OPERATION Exploratory Laparotomy
20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* 6-29, 1948 *to* Aug. 15, 1949 *that I last saw the deceased alive on* Aug. 15 1949, *and that death occurred at* 1.30 am., *from the causes and on the date stated above.*

23A. SIGNATURE C. S. Organ M. D.
23B. ADDRESS 4940 Eastern Ave.
23C. DATE SIGNED Aug. 15-1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/18/49
24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus
24D. LOCATION (City, town, or county) Baltimore (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 16 1949
REGISTRAR'S SIGNATURE Municipal Tax Williams, M.D.
25. FUNERAL DIRECTOR Milhorn & Doe
ADDRESS 1214 Lond St

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and forcibly. Exact age is especially important.

AB-123831
G77291
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81

G77291
Registered No.

1. NAME OF DECEASED (Type or Print): David Orem

2. DATE OF DEATH: August 13-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1913 Eutaw Place Nursing Home 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Divorced	Sept- 8- 1879	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TEXTILE WORKER
10B. KIND OF BUSINESS OR INDUSTRY: TWINE AND CORDAGE
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Orem
14. MOTHER'S MAIDEN NAME: Margaret Knapp
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-07-6325
17. INFORMANT Records: Baltimore City Hospitals 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypo-Static Pneumonia
DUE TO
(B) Carcinoma of Bladder
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: Aug. 4- 1948
19B. MAJOR FINDINGS OF OPERATION: Super-pubic Cystotomy
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-18- , 1948 *to* 8-13- , 1949 *that I last saw the deceased alive on* 8-13- , 1949, *and that death occurred at* 12.07 AM *from the causes and on the date stated above.*

23A. SIGNATURE: J. J. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: Aug. 13-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 16 1949
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn.
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: AUG 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Paul E. Lehmann Jr.
ADDRESS: 3542 Eastern Ave

VS 150

52B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully collected as is especially important. Physician, please write the cause of death clearly and legibly.

G77292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

584

G77292 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ruth G GREEN

2. DATE OF DEATH Aug 12 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4210 Ivanhoe Ave.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 4210 Ivanhoe Ave. 27 10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	married.	Dec 27 1907	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Robert E. Gray
14. MOTHER'S MAIDEN NAME Dora Dusi
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216 10-4418
17. INFORMANT ADDRESS Wm H E Green 4210 Ivanhoe Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Obstruction of Common bile duct — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

(B) Operation - Cholecystectomy 5 operations. — 3 yrs

DUE TO

(C) acute cholecystitis — 3 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

none

19A. DATE OF OPERATION 1947 - 49
19B. MAJOR FINDINGS OF OPERATION Removal of common bile duct
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) none
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) none
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 9 1949 *to* Aug 17 1949, *that I last saw the deceased alive on* Aug 11 1949, *and that death occurred at* 1 55 AM *from the causes and on the date stated above.*

23A. SIGNATURE A. S. Chesnut M. D.
23B. ADDRESS 6210 York Rd
23C. DATE SIGNED Aug 12 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 15, 1949
24C. NAME OF CEMETERY OR CREMATORY Woodlawn
24D. LOCATION (City, town, or county) (State) Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 16 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Paul E. Lehmann
ADDRESS 3615-17 Eastern Ave

VS 150

127a

G77293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 D

G77293 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK W BROOKS

2. DATE OF DEATH Aug 13 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3014 Darley Lt.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 3014 Darley Lt. 13-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	White	married.	Jan 21 1881	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plumber.	Self.	Md.	

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	218-18-0873	Mrs Bertha Metzger	3014 Darley Lt.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

(B) Heart Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 27, 19 49 *to* Aug 14, 19 49, *that I last saw the deceased alive on* Aug 13, 19 49 *and that death occurred at* m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leonard Wallenstein M. D.	814 N 36th St	8/15/49

24A. (BURIAL, CREMATION, REMOVAL) (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 16 1949	Loraine Park.	Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williams, M.D.	Paul E. Schwartz Jr.	3615-17 Edmondson Ave

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

G77294

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77294

1. NAME OF DECEASED (Type or Print) Minnie Gliewe

2. DATE OF DEATH Aug. 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 503 Arlington Ave. (Govans)

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE B. COUNTY 503 Arlington Ave
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md
D. STREET ADDRESS (If rural, give location) 503 Arlington, Ave. 27-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Oct. 16, 1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	U.S.A.

13. FATHER'S NAME Frederick Schmidt

14. MOTHER'S MAIDEN NAME Katherine Baltz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO.

17. INFORMANT Otto R. Gliewe ADDRESS 503 Arlington Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pulmonary Edema	3 days
DUE TO	(B) Cardiac dilatation	unknown
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	(C) Hypertensive cardiovascular disease "	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Old cerebral hemorrhage	8 months

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCoccur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/9/49, 19__, *to* 8/14/49, 19__, *that I last saw the deceased alive on* 8/14, 1949 *and that death occurred at* 8 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Anthony J Thomas M. D.	4600 York Road	8/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	August 17 1949	Emmanuel's Cem	Govans Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williams, M.D.	John C. Moran	3000 E. Baltimore St.

VS 150

931

G77295

BALTIMORE CITY HEALTH DEPARTMENT E931 G77295

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Braxton Allen N-9813

2. DATE OF DEATH 8-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hosp.

C. Length of stay in Baltimore 15-2m (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN Balto (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1514 Pine St 16-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	(D)	1/1/1908	41 42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor

10B. KIND OF BUSINESS OR INDUSTRY BUILDING CONST.

11. BIRTHPLACE (State or foreign country) Rockingham NC

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Braxton Allen

14. MOTHER'S MAIDEN NAME Mary J. Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Bertha McCullah ADDRESS 819 W Lanvale St

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Heat exhaustion.		
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-11, 1949 *to* 8-11, 1949 *that I last saw the deceased alive on* 8-9, 1949 *and that death occurred at* 4:00 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE Lucie W Logan M.D. M. D.

23B. ADDRESS Provident Hosp

23C. DATE SIGNED 8-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/16/49	Mt Calvary	A A Co., Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 16 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR J. L. Brown & Son ADDRESS 1018 W Montgomery St

VS 150

191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77296

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

5-3

G77296 Registered No.

1. NAME OF DECEASED (Type or Print) Veronica Pradich

2. DATE OF DEATH 8/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-07
D. STREET ADDRESS (If rural, give location) 320 Oldham St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 320 Oldham St.

C. Length of stay in Baltimore 3 2 Yrs. Mos. Days

5. SEX F.
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 31, 1900
9. AGE (In years last birthday) 49
If Under 1 Year: Months — Days 12 — If Under 24 Hours: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. W.
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Czechoslovakia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Andrew Baran

14. MOTHER'S MAIDEN NAME Wanya, Anna.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Sophie Koski ADDRESS 361 S Ellwood St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) C A, Laryngitis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 2 yrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 5 1949, to Aug 12, 1949, *that I last saw the deceased alive on* Aug 9, 1949, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Maurice L Shut M. D.
23B. ADDRESS 1431 A Kendall Ave
23C. DATE SIGNED Aug. 12/1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/16/49
24C. NAME OF CEMETERY OR CREMATORY Sacred Heart
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 16 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Lilly + Zeiler Inc ADDRESS 403 S. Wolfe St

VS 150

46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician please write the cause of death clearly and legibly.

77297 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 977.0 G77297 Registered No.

1. NAME OF DECEASED (Type or Print) FANNIE SINSKEY

2. DATE OF DEATH August 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5430 Price Avenue
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5430 Price Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Married		58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) London Eng
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Abrahaim Steinberg
14. MOTHER'S MAIDEN NAME Sarah
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Isidore Sinskey ADDRESS 5430 Price Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Exsanguination due to laceration of left wrist
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5430 Price Avenue
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY August 14, 1949 ? m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Slashed own wrist with razor blade

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE H. L. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR
23C. DATE SIGNED August 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-16-49	Hebrew Friendship	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 16 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

VS 151

164 D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. See instructions on back. Physicians: please write the cause of death clearly and legibly. Please correct age as especially important.

G77298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77298

BIRTH NO. 49-16388

1. NAME OF DECEASED (Type or Print) Baby Boy Ross

2. DATE OF DEATH 8/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 227 E. Churchill Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	8/3/49				5	12

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	

13. FATHER'S NAME Ernest Ross

14. MOTHER'S MAIDEN NAME Frances Send

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxia DUE TO Premature separation of placenta

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/2/49, 19__, *to* 8/2/49, 19__, *that I last saw the deceased alive on* 8/3/49, 19__, *and that death occurred at* 12:20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. K. Hollister M. D.	1212 Light St.	8/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL AUG 9 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 16 1949	Huntington Williams, M.D.	Commissioner of Health

VS 150

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

160c

G77299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77299

BIRTH NO. B.C. 49-16640

1. NAME OF DECEASED (Type or Print): William Lavelle Ridge, Jr.

2. DATE OF DEATH: August 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOCTOR'S HOSPITAL
C. Length of stay in Baltimore: 4 hours 45 minutes (Yrs. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 835 William Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Infant	August 6, 1949				4	45

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: William Lavelle Ridge
14. MOTHER'S MAIDEN NAME: Anna Marie Lulie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Six month Premature Birth — INTERVAL BETWEEN ONSET AND DEATH: 4hrs.45min
DUE TO
(B) Bridge Birth
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-6, 1949 *to* 8-6, 1949 *that I last saw the deceased alive on* 8-6-1949, *and that death occurred at* 1038 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D. | 23B. ADDRESS: 2730 N Charles St | 23C. DATE SIGNED: 8/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL | 24D. LOCATION (City, town, or county) (State): AUG 11 1949

DATE RECEIVED BY LOCAL REGISTRAR: AUG 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77300

BIRTH NO. B.C. 49-15053

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

135 G77300
Registered No.

1. NAME OF DECEASED (Type or Print) BABY BOY HATHER

2. DATE OF DEATH JULY 22, '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL

c. Length of stay in Baltimore PREMATURE INFANT Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 609 W. SARATOGA

4-02

5. SEX M | 6. COLOR OR RACE B | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH JULY 17, '49 | 9. AGE (In years last birthday) | If under 1 Year: Months / Days 5 | If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY INFANT

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Mrs Hatcher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS 607 W Saratoga St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cooperation Pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. prematurity

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION None | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-17-49 *to* 7-22-49, *that I last saw the deceased alive on* 7-22-49, *and that death occurred at* 4:35 *m., from the causes and on the date stated above.*

23A. SIGNATURE J. V. Munor M. D. | 23B. ADDRESS University Hosp | 23C. DATE SIGNED 7-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL | 24D. LOCATION (City, Town, or county) (State) AUG 9, 1949

DATE RECEIVED BY LOCAL REGISTRAR AUG 16 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Commissioner of Health | ADDRESS

VS 150

159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G77301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77301

BIRTH NO. B.C.49-15896

1. NAME OF DECEASED (Type or Print): Anderson, Baby Boy

2. DATE OF DEATH: 8/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland ~~Hosp~~

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17
D. STREET ADDRESS (If rural, give location): 627 Lafayette Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Single	7/31/49		2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Balto, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wilbert Anderson

14. MOTHER'S MAIDEN NAME: Juanita Chew.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Juanita Anderson ADDRESS: 627 Lafayette Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity { Atelectasis / Intestinal Hemorrhage

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* —, 19—, *to* —, 19—, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* 12:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jarrett E Deane M. D.

23B. ADDRESS: University Hospital

23C. DATE SIGNED: 8/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): —

24B. DATE: —

24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State): AUG 11 1949

25. FUNERAL DIRECTOR: Commissioner of Health

ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: AUG 16 1949

REGISTRAR'S SIGNATURE: [illegible]

VS 150

159

G77302

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

44

Registered No. G77302

1. NAME OF DECEASED (Type or Print) — Henrietta Lee

2. DATE OF DEATH — Aug 12-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 136 W. Cross St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

C. Length of stay in Baltimore — 50 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — 136 W. Cross St
B. COUNTY — Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Balto. Md.
D. STREET ADDRESS (If rural, give location) — 136 W. Cross St 23-01

5. SEX — Female
6. COLOR OR RACE — Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) — Widow
8. DATE OF BIRTH — May 1894
AGE (In years last birthday) — 55
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — Housewife
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) — Hagerstown Md
12. CITIZEN OF WHAT COUNTRY? — U.S.A.

13. FATHER'S NAME — Alexander Chase
14. MOTHER'S MAIDEN NAME — Jennie —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT — Jennie S. A. Lee
ADDRESS — 136 W. Cross St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure
DUE TO
(B) Hemiplegia
DUE TO
(C) Arteriosclerotic Cardiovascular renal disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH —

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE? (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* June, 1949, to Aug 12, 1949, *that I last saw the deceased alive on* Aug 11, 1949, *and that death occurred at* 1.30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE — I. Abrahofsky M.D. M. D.
23B. ADDRESS — 601 N. Monroe St.
23C. DATE SIGNED — 8/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify) — Burial
24B. DATE — Aug 16-49
24C. NAME OF CEMETERY OR CREMATORY — Mt. Auburn
24D. LOCATION (City, town, or county) (State) — Balto

DATE RECEIVED BY LOCAL REGISTRAR — AUG 16 1949
REGISTRAR'S SIGNATURE — Hattie Gov. Williams, M.D.
25. FUNERAL DIRECTOR — James Adams
ADDRESS — 142 Wolfe St

VS 150

1312

PLEASE WRITE PLAINLY, WITH UNFAILING INK. Every item of information should be carefully considered. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G77303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77303

BIRTH NO. B.C.49-17936

1. NAME OF DECEASED (Type or Print): Baby Boy Curtian

2. DATE OF DEATH: Aug 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 23
D. STREET ADDRESS (If rural, give location): 2557 Frederick Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Aug 10 1949
9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min.: 4 hrs 33

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Carroll Curtian Jr
14. MOTHER'S MAIDEN NAME: Catherine Grace Rhodes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother
ADDRESS: 2557 Frederick Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Premature Separation of Placenta

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Toxemia of Pregnancy

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 8/10, 1949, *to* 8/10, 1949 *that I last saw the deceased alive on* 8/10, 1949, *and that death occurred at* 7:50 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Norman L Evans M. D.
23B. ADDRESS: West Balto Gen Hosp
23C. DATE SIGNED: 8/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, Town, or County) (State):

DATE RECEIVED BY LOCAL REGISTRAR: AUG 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
ADDRESS:

JOHNS HOPKINS MEDICAL SCHOOL AUG 15 1949

Commissioner of Health

VS 150

160 c.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Be sure to give correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G77304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-17012

Registered No. G77304

1. NAME OF DECEASED (Type or Print): BABY GIRL FORBES

2. DATE OF DEATH: 8 Aug. 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

C. Length of stay in Baltimore: 2 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: BALTIMORE CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. CITY 16-0
D. STREET ADDRESS (If rural, give location): 1005 N. STRICKER ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	S	6 Aug 49		2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	NEWBORN	BALTO. MD	USA

13. FATHER'S NAME: W. F. GRIES

14. MOTHER'S MAIDEN NAME: DORA FORBES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		MOTHER	1005 N STRICKER

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 2D

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6 Aug, 1949 *to* 8 Aug, 1949 *that I last saw the deceased alive on* 8 Aug, 1949, *and that death occurred at* 9:15 a *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Blackburn B. Joslin M. D.	University Hosp.	8 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL AUG 11 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 7 1949	Huntington Williams, M.D.	COMMISSIONER OF HEALTH	

VS 150

159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G77305

BIRTH NO. B.C.49-15936

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160.5

G77305 Registered No.

1. NAME OF DECEASED (Type or Print): OTIS STEVISON DODSON

2. DATE OF DEATH: August 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
c. Length of stay in Baltimore: 1 1/2 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1604 Madison Ave #17 14-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Single	August 1, 1949		1½	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant	none	Maryland	USA

13. FATHER'S NAME: Melvin Dodson

14. MOTHER'S MAIDEN NAME: Geneva Olds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	—	none	Father	1004 Madison Ave #17

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 9:45 A.M. on August 1 to 3:30 P.M. August 2
DUE TO
(B)
DUE TO
(C) Intracranial hemorrhage — 31 hours 45'

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Prematurity

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	none	no

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* August 1, 1949, *to* August 2, 1949, *that I last saw the deceased alive on* August 2, 1949, *and that death occurred at* 3:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles T. Henderson M. D.	University Hospital	August 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL AUG 11 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 6 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

160a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G77306

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54

G77306

Registered No.

1. NAME OF DECEASED (Type or Print): JAMES R CARROLL

2. DATE OF DEATH: 8/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY Hospital

c. Length of stay in Baltimore: 61 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 21-07
D. STREET ADDRESS (If rural, give location): 1220 WASHington Blvd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	White	MARRIED	July 25, 1888	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CLERK	City Hall	MARYLAND	U.S.A

13. FATHER'S NAME: JAMES R. CARROLL

14. MOTHER'S MAIDEN NAME: DORA V. EINOLF

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		WIFE	SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized carcinomatosis DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) carcinoma of rectum DUE TO — 5 yrs.
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
May 24, 1949	inoperable CAR. of rectum	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 1949 *to* Aug 14, 1949 *that I last saw the deceased alive on* 8/14/49 19__, *and that death occurred at* 10:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Gene M. Tressin M. D.	Mercy Hospital	8/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	8/17/49	New Cathedral Cem.	4300 Old Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williams, M.D.	John J. Conway	460

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77307

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77307

1. NAME OF DECEASED (Type or Print): ELEANOR J. OEHM

2. DATE OF DEATH: Aug. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2155 Chelsea Terrace
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2155 Chelsea Terrace 15-48

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	Mar. 16, 1871	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home	Domestic	Newark, N. J.	USA

13. FATHER'S NAME: Otto Molter

14. MOTHER'S MAIDEN NAME: Johanna Vesper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Mrs. Robert M. Brown	2155 Chelsea Terrace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory failure
DUE TO
(B) Arteriosclerotic Cardiovascular renal disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 11, 1949 *to* Aug 14, 1949 *that I last saw the deceased alive on* Aug 13, 1949, *and that death occurred at* 3:50 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Abrahofsky M. D. M. D. | 23B. ADDRESS: 601 N. Monroe St. | 23C. DATE SIGNED: 8/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/16/49	Lorraine Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 16 1949 | REGISTRAR: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Wm. J. TICKNER & SONS INC. | ADDRESS: North & Pa. Balto. 17, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

131a

G77308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77308

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Minnie * Myers * JULIA

2. DATE OF DEATH: 8/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp
C. Length of stay in Baltimore (Yrs. Mos. Days): Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3833 Brooklyn Ave #25

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W		Oct. 9, 1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	Domestic	Maryland	USA

13. FATHER'S NAME: August C. Schmidt

14. MOTHER'S MAIDEN NAME: ? Wagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Mr. August C. Myers	38ss Brooklyn Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema

DUE TO

(B) Arteriosclerotic Heart disease & failure

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/10/49, 19__, *to* 8/15/49, 19__, *that I last saw the deceased alive on* 8/15, 19 49, *and that death occurred at* 4:40 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Arlyn H. Wood M. D.	West Balt. General Hosp.	8/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/18/49	Cedar Hill Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS INC.	North & Pa. Balto. 17, Md.

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered correctly and legibly. The cause of death clearly and legibly. Physician: please write the correct age is especially important.

G77309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

41

G77309

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FREDERICK E. GREEN

2. DATE OF DEATH Aug. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1637 Lochwood Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1637 Lochwood Rd. 25-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	May 30, 1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Commission Merchant	Commission	Marion Station, Md.	USA

13. FATHER'S NAME: Thomas J. Green

14. MOTHER'S MAIDEN NAME: Virginia Carver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	None	Mrs. Minnie C. Green	1637 Lochwood Rd.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as correctly and fully as possible. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 days.

DUE TO

(B) Chronic bronchial asthma 4 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/9, 1949 *to* 8/13, 1949, *that I last saw the deceased alive on* 8/13, 1949, *and that death occurred at* 4.45 P.M. *the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. Willis Gaynor M. D.	3961 Greenmount Ave	8/16/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/17/49	Lorraine Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williams, M.D.	WM. J. TURNER & SONS INC.	North & Pa. Aves Balto. 17, Md.

VS 150

94a

G77310

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No. G77310

1. NAME OF DECEASED (Type or Print) William Hill Wootton

2. DATE OF DEATH 8-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. Length of stay in Baltimore — Yrs. 12 Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 104 W. University Parkway

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Dec. 24 - 1875	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Insurance	Maryland	USA

13. FATHER'S NAME Richard Wootton

14. MOTHER'S MAIDEN NAME Elise Contee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		None	Sister	Mrs. Olive Joyner Wootton 104 W. University Pkwy.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and fully.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio Vascular Disease — 10 yrs.

DUE TO

(C) Arteriosclerosis - general —

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-14-49, 19—, *to* 8-15, 1949, *that I last saw the deceased alive on* 8-15, 1949, *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Wootton Gosbee M. D.	Union Memorial Hospital	8-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/17/49	Druid Ridge Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
8/16/1949	Huntington Williams, M.D.	J. TICHNER & SONS INC.	North & Pa. Balto. 17, Md.

VS 150

937

G77511

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43

Registered No. G77511

1. NAME OF DECEASED (Type or Print): GUY W. FRAZIER

2. DATE OF DEATH: Aug. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4804 Keswick Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 65 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4804 Keswick Rd. 2714

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	Aug 15, 1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk Retired	Railroad	Reisterstown, Md.	USA

13. FATHER'S NAME: Thomas J. Frazier

14. MOTHER'S MAIDEN NAME: Elinor Gibson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
None	?	Mr. Sterling Riley	2128 N. Fulton Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given carefully and correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage, basilar — INTERVAL BETWEEN ONSET AND DEATH: 48hs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertensive Cardio-Vascular disease — 3yrs

DUE TO

(C) Previous Cerebral hemorrhage — 12 weeks

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 30 1949, *to* August 15, 1949, *that I last saw the deceased alive on* August 14 1949, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Newland Edward Day M. D.	4-E-33rd St -18	August 16/1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	8/17/49	Greenmount Crematory	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	[illegible] Williamsport, Md.	WM. J. TICKNER & SONS INC.	North & Pa. Aves Balto. 17, Md.

VS 150

93D

G27312

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G27312

1. NAME OF DECEASED (Type or Print) — MARY T. CONNOR — Mary Connor

2. DATE OF DEATH — 8/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Mercy Hosp
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — Mercy Hospital
C. Length of stay in Baltimore — Life 70 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Baltimore, Md.
D. STREET ADDRESS (If rural, give location) — 743 Mc Cabe Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	Widow	Jan 22 1879	70	6	22

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md	U.S.A.

13. FATHER'S NAME — Thomas Mc Coffery

14. MOTHER'S MAIDEN NAME — Alice Leeden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	✓	

17. INFORMANT — ADDRESS — Mrs. Louis H Wheeler 743 McCabe Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

DUE TO

(B) arteriosclerosis

DUE TO

(C) Ovarian Tumor

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8/12/49	Ovarian Tumor?	YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/8, 1949 *to* 8/14, 1949 *that I last saw the deceased alive on* 8/14, 1949, *and that death occurred at* 1 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Richard Trawl M. D.	Mercy Hospital	8/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/17/49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Municipal Registrar, Baltimore, Md.	Chas. J. Evans & Son, Inc.	118 West Mount Royal ave.

VS 150

56a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item is important. Physician: please write the cause of death clearly and correct age is especially important.

G77313

420.1

G77313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 77313

BIRTH NO.

1. NAME OF DECEASED (Type or Print): AGNES KATHERINE WAGNER

2. DATE OF DEATH: August 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — 2007 Cecil Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 50 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 9-08
D. STREET ADDRESS (If rural, give location): 2007 Cecil Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Jan. 7, 1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at Home	-	Altoona, Pa.	-

13. FATHER'S NAME: Joseph Lergen Miller

14. MOTHER'S MAIDEN NAME: Otilia -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
-	-	-

17. INFORMANT: Mr. Richard Wagner, ADDRESS: 30 Gorman Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Degenerative Cardio Vascular Disease — 1 yr. ?

DUE TO

(C) Chronic Coronary Insufficiency

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
-	-	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
-	-	-

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
- m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	-

22. *I hereby certify that I attended the deceased from* Aug. 8, 1949 *to* Aug. 15, 1949 *that I last saw the deceased alive on* Aug. 15, 1949 *and that death occurred at* 3:45A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph E. Muse Jr. M.D.	5 W. 29th Street	8/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 18, '49	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Aug. 16, '49	Huntington Williams, M.D.	Chas. G. Evans & Son, Inc.,	118 W. Mt. Royal

VS 150

93D

Please write clearly and legibly. Physician's please write the cause of death clearly and legibly. Physician's please write the cause of death clearly and legibly. Physician's please write the cause of death

G77314

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77314

1. NAME OF DECEASED (Type or Print): Patricia Ann Palmer

2. DATE OF DEATH: 8-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: Yrs. Mos. 2 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Calvert
CITY OR TOWN (If outside corporate limits, write RURAL and give township): North Beach, Md.
D. STREET ADDRESS (If rural, give location)

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 10-17-47
9. AGE (In years last birthday): 2
If Under 1 Year: Months 9 Days 29
If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Andrea, Miss.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Willie Palmer
14. MOTHER'S MAIDEN NAME: Ruby Brown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Peritonitis — INTERVAL, BETWEEN ONSET AND DEATH: 5 days
DUE TO
(B) Acute Gangrenous Appendicitis (Perforated). — 12 hrs.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 8-11-49
19B. MAJOR FINDINGS OF OPERATION: Gangrenous Appendicitis, Perforated
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-14-, 1949 to 8-16-1949 that I last saw the deceased alive on 8-16-1949, and that death occurred at 6:50 A m., from the causes and on the date stated above.

23A. SIGNATURE: Henry O. Kern M. D.
23B. ADDRESS: Maryland General Hosp.
23C. DATE SIGNED: 8-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 16-1949
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Wash D C

DATE RECEIVED BY LOCAL REGISTRAR: AUG 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: J. Wm. Lee Sons Co.
ADDRESS: 121 Washington D C

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as far as possible. Cause of death must be certified and signed by physician. Physician: please write the cause of death clearly and legibly. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

77315

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77315

Registered No.

1. NAME OF DECEASED (Type or Print) SHIRLEY MAY BUTLER

2. DATE OF DEATH AUGUST 12 1949 10.30 PM

3. PLACE OF DEATH:
A. Baltimore City, Maryland FRANKLIN SQUARE Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE Hosp.
C. Length of stay in Baltimore LIFE. Yrs. 8. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 633 CARROLTON 16-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	Col.	BABY	Oct. 24 1948		8			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
/	/	MARY LAND	U.S.A.

13. FATHER'S NAME: BUTLER. EDWARD

14. MOTHER'S MAIDEN NAME: INES O'CONNOR.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		EDWARD BURGER	FRANKLIN SQUARE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dehydration. — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO Nausea, vomiting diarrhea

(B)

DUE TO acidosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) — No P.M. EXAM.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

PERMITTED.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10 pm 8/12, 19 49 *to* 10.30 pm 8/12 19 49 *that I last saw the deceased alive on* 8/12, 19___, *and that death occurred at* 10.30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward Burger M. D.	Franklin Square	8/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 16 1949	Mt Lebanon	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	[illegible]	Mr Peter R. Williams	332 N [illegible]

VS 150

11.9a

PLEASE WRITE PLAINLY with pen and ink. Report one cause of death clearly and correct age is especially important. Physicians: please write the cause of death clearly and

G77316

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 953

Registered No. G77316

1. NAME OF DECEASED (Type or Print): THELMA MABEL N-5574.0

2. DATE OF DEATH: August 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland University Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 200 W. Camden Street 22-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow	October 31, 1908	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Roy Moore	Lottie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Ethel Mable	677 Vine St

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subdural Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Public	200 W. Camden Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 8, 1949 approx. 9:30a m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Blunt force

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]	23C. DATE SIGNED
George G. Merrill M.D.		August 13, '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 17, 1949	Mt. Auburn	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williams, M.D.	Mrs. Katie A. Williams	322 N Gilmor St

VS 151

168

G77317

BIRTH NO. B.C.H. 4998

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 983.0 G77317 Registered No.

1. NAME OF DECEASED (Type or Print): Daniel Chesley — N-863.6

2. DATE OF DEATH: Aug. 13, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospital

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1036 Eutaw St. 11-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Child	June 12, 1946	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Chesley

14. MOTHER'S MAIDEN NAME: Rhodella Washington.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Artellia Washington — ADDRESS: 1036 Eutaw St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized peritonitis

DUE TO

(B) Rupture of Duodenum

DUE TO

(C) Traumatic

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 335 B Fliker Court, Turners Station

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): August 13, 1949 m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Blunt force

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Earl L. Rose M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 14 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Aug 17, 1949

24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 16 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Mrs Kate R. Williams — ADDRESS: 322 N Schroeder St

VS 151

168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be answered. Be sure the cause of death clearly and fully stated. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

77318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 90-0 77318

Registered No. 77318

BIRTH NO. B.C. 49-25389

1. NAME OF DECEASED (Type or Print): GWENDOLYN DIGGS N 803.0

2. DATE OF DEATH: August 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 520 W. Biddle Street 17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Child	Nov. 11, 1948		9			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore Md.	

13. FATHER'S NAME: James Simpson.

14. MOTHER'S MAIDEN NAME: Cornelia Diggs.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: James Simpson. ADDRESS: 520 W. Biddle St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 520 W. Biddle Street 17/1

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: August 14, 1949 10A. m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Fell from third story window

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: H. J. McCafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 8-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 17, 1949	Mt Auburn	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williams, M.D.	Mrs. Fotie R. Williams	3221 Edmondson

VS 151

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry item 6 (Color or Race), 7 (Single, Married, Widowed, Divorced), 8 (Date of Birth), 9 (Age), 10 (Occupation), 11 (Birthplace), 13 (Father's Name), 14 (Mother's Maiden Name), 17 (Informant), 18 (Cause of Death), 19 (Operation), 20 (Autopsy), 21 (Injury), 22 (Certification), 23 (Signature), 24 (Burial), 25 (Funeral Director). Be sure to write the cause of death clearly and legibly. Physician: please write correct age if especially important.

G77319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50.0

G77319

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Charles Ames

2. DATE OF DEATH Aug 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2231 E. Biddle St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-04

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2231 E. Biddle St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Widowed	July 1 1857	92	9 14	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
PORTER	REAL ESTATE OFFICE	Maine	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 16 1949 *to* Aug 13, 1949 *that I last saw the deceased alive on* Aug 13, 1949, *and that death occurred at* 12 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	1250 E North Ave	Aug 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
8-16-49	Burial	Mt. Carmel	O'Donnell St. - Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williams, M.D.	John P. Melly, Inc.	2432 E. Oliver St.

VS 150

97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Write the cause of death clearly and legibly. Exact age is especially important. Physicians: please write the

G77320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

G77320

Registered No.

BIRTH NO. (

1. NAME OF DECEASED (Type or Print) **Hattie Simpson Cooper**

2. DATE OF DEATH **Aug. 13.1949**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **Balto.**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **20 South Bond Street**
C. Length of stay in Baltimore **Life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Balto.**
D. STREET ADDRESS (If rural, give location) **20 South Bond Street** 3-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	**Col.**	**Single**	**Sept. 18 1890**	**58**		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		**Balto. Md.**	**U.S.A.**

13. FATHER'S NAME **John Simpson**

14. MOTHER'S MAIDEN NAME **Mary Richerson**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Viola Jones	**20 S. Bond St.**

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Chronic Cardio-Renal Vascular Disease** — INTERVAL BETWEEN ONSET AND DEATH: **3 mos.**

DUE TO

(B) **Cerebral Apoplexy** — **1 yr.**

DUE TO

(C) **Hypertension** — **?**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* **May 12**, 19**49** *to* **Aug 13**, 19**49** *that I last saw the deceased alive on* **Aug 13** 19**49**. *and that death occurred at* **1.30** *A.M., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. L. Ray Berry M. D.	**1420 E. Chase**	**Aug 16 '49**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**Aug. 17. 1949**	**Mt Calvery Cem.**	**Brooklyn Md.**

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 18 1949	Huntington Williams, M.D.	**Elroy O. Wilson**	**1000 Brantly Ave**

VS 150

135a

Please write the cause of death clearly and legibly. Physician: please write the exact age if especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77321 BIRTH NO. 163 Registered No. G77321

1. NAME OF DECEASED (Type or Print) James Williams

2. DATE OF DEATH Aug. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S. Marine Hospital Baltimore, Maryland

c. Length of stay in Baltimore Unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 529 Pressman Street 14-03

5. SEX Male | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Separated | 8. DATE OF BIRTH June 6, 1895 | 9. AGE (In years last birthday) 54 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Mason | 10B. KIND OF BUSINESS OR INDUSTRY SELF

11. BIRTHPLACE (State or foreign country) South Carolina | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Williams

14. MOTHER'S MAIDEN NAME Mary Jane ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes | (If yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO. unknown

17. INFORMANT Records, US Marine Hospital, Balto., Md. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the right lung
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Duration unknown

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 14, 1949 *to* Aug. 14, 1949 *that I last saw the deceased alive on* Aug. 14 1949 *and that death occurred at* 2:40 A *m., from the causes and on the date stated above.*

23A. SIGNATURE John L. Wilson
John L. Wilson, Medical Director M. D. | 23B. ADDRESS US Marine Hospital, Balto., Md. | 23C. DATE SIGNED 8-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug 19 49 | 24C. NAME OF CEMETERY OR CREMATORY South View Cem. | 24D. LOCATION (City, town or county) (State) Augusta Ga

DATE RECEIVED BY LOCAL REGISTRAR AUG 17 1949 | REGISTRAR'S SIGNATURE Huntington Williams, MD | 25. FUNERAL DIRECTOR Clary O. Wilson | ADDRESS 1010 Broadway

VS 150

47D

Please write plainly with pen and ink. Be sure the cause of death clearly and correct age is especially important. Physicians: please write the

G77322

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1949

G77322

Registered No.

1. NAME OF DECEASED (Type or Print) ANNA A. WHITING

2. DATE OF DEATH 8/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 514 East 23rd Street

c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 514 East 23rd Street 9-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home	-	Baltimore	

13. FATHER'S NAME: Patrick Mullin

14. MOTHER'S MAIDEN NAME: Mary Quane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no	-	-

17. INFORMANT: Mr. Raymond A. Whiting ADDRESS: 514 East 23rd Stree

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma left breast	16 mo.
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
April 30, 1948	Carcinoma left breast.	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 22, 1948 *to* Aug. 13, 1949 *that I last saw the deceased alive on* Aug. 13, 1949 *and that death occurred at* 12:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Tumulty M. D.	Medical Arts Bldg.	Aug. 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	8/17/49	Cathedral	City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williams, M.D.	WIEDEFELD & SON	GREENMOUNT AVE & 22ND

VS 150

50

Please write plainly with ink. Be sure the cause of death clearly and correct age is especially important. Physicians: please write the

G77323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77323

BIRTH NO. B.C. 49-17601

1. NAME OF DECEASED (Type or Print): Baby Boy Thompson

2. DATE OF DEATH: 8/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy
C. Length of stay in Baltimore: 2 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)
D. STREET ADDRESS (If rural, give location): R.F.D. #6. WESTMINSTER. MD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	single	8/11/49			2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Mercy Hosp	

13. FATHER'S NAME: Howard M. Thompson

14. MOTHER'S MAIDEN NAME: Ebelina Millegan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) atelectasis
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 days

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/1 *, 1949, to* 8/13 *, 1949, that I last saw the deceased alive on* 8/13 *, 1949, and that death occurred at* 3:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Josephs, M. D.	Mercy Hosp	8/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	8-17-49	St. Peters	City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williams, M.D.	Wiedefeld & Son	Green Mount Ave & 22nd — 1610

VS 150

PLEASE WRITE LEGIBLY WITH UNFADING INK. Please write the cause of death clearly and correct age is especially important. Physician: please

G77324

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77324

1. NAME OF DECEASED (Type or Print): THOMAS A. JACKSON

2. DATE OF DEATH: Aug 15th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
c. CITY OR TOWN: Balto
(If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1512

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: June 6 1892
9. AGE (If years last birthday): 57
If Under 1 Year: Months 2 Days 13
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman
10B. KIND OF BUSINESS OR INDUSTRY: DEPT. OF HIGHWAYS Balto City
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY:
13. FATHER'S NAME: Benjamin Jackson
14. MOTHER'S MAIDEN NAME: Ida Baltimore
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): YES WORLD WAR I
16. SOCIAL SECURITY NO.: 212-10-1792
17. INFORMANT: Emma Esther Jackson ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(B) Arteriosclerotic cardiovascular disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 10th, 1949 *to* Aug 15, 1949, *that I last saw the deceased alive on* Aug 15, 1949 *and that death occurred at* 1.02 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Katharine V. Krantz M. D.
23B. ADDRESS: West Balto Gen Hosp
23C. DATE SIGNED: Aug 15th 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 18-49
24C. NAME OF CEMETERY OR CREMATORY: Balto National
24D. LOCATION (City) (town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ellsworth Armacost
ADDRESS: 5118 Harford Oak Ave: 93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as to the cause of death clearly and legibly. Date of death is especially important. Physician: please write the

VS 150

G77325

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163 Registered No. G77325

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH GREENLEAF McDANIEL

2. DATE OF DEATH August 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3429 Woodstock Avenue
c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3429 Woodstock Avenue 8 01

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWER, DIVORCED (Specify) Widowed
8. DATE OF BIRTH July 17, 1878
9. AGE (In years last birthday) 71 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter - ret.
10B. KIND OF BUSINESS OR INDUSTRY Crown Cork &Seal
11. BIRTHPLACE (State or foreign country) Co. Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John F. McDaniel
14. MOTHER'S MAIDEN NAME Adeline Henderson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-01-1878
17. INFORMANT Mrs. Herbert Krause ADDRESS 3429 Woodstock Ave. 13

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of Left Lung	about 9 mos.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C) abcess of left lung.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION Feb. 28th. 1949
19B. MAJOR FINDINGS OF OPERATION Adeno Carcinoma of left lung.
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/14/49, 19__, *to* 8/13/, 1949, *that I last saw the deceased alive on* 8/13/, 1949, *and that death occurred at* 8:30P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Geo. W. Morgan M. D.
23B. ADDRESS 401 E. 25th. St.
23C. DATE SIGNED 8/15/49.

24A. BURIAL, CREMATION, REMOVAL (Specify) burial
24B. DATE 8/17/49
24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 16 1949
REGISTRAR'S SIGNATURE Contagion for Williams M.D.
25. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.
ADDRESS BALTIMORE - 13, MARYLAND 47D

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Be sure to write the cause of death clearly and correct age is especially important. Physician: please write legibly.

G77326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77326

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JANE GENTILA

2. DATE OF DEATH August 15, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore 50 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 38 Parkin Street 18-03

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Unknown 1877
9. AGE (In years last birthday): 72 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailoring
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ignatius Gentila
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Daniel Gentila ADDRESS 3704 Eastfolk Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 8-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/18/49
24C. NAME OF CEMETERY OR CREMATORY Lorraine Cem.
24D. LOCATION (City, town, or county) (State) 5608 Dogwood Rd.

DATE RECEIVED BY LOCAL REGISTRAR AUG 18 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR John J. Cowan & Son ADDRESS 930 Hollins St.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of the cause of death clearly and legibly. Correct age is especially important. Physician: please write the cause

G77327

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

146 Registered No. G77327

1. NAME OF DECEASED (Type or Print) PARKER SMITH

2. DATE OF DEATH August 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1807 Franklin St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1807 W Franklin St. Balt., Md

c. Length of stay in Baltimore 2 Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

c. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) 1807 Franklin St. 20-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	married	Unknown	92		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired LABORER	ODD JOBS	Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		James Smith	(1807 W. Franklin St.)

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Generalized arteriosclerosis - Nephrosclerosis	
DUE TO		
	(B) Terminal uremia	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
—	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 8/12, 1949, *to* 8/14, 1949, *that I last saw the deceased alive on* 8/13, 1949, *and that death occurred at* 9:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James Mahon M. D.	5804 Edmondson Ave. Balt, Md	8/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/18/49	Mt. Zion Cemetery	Washington, D.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Hunter for Williams, M.D.	Charles L. Law	502 Park Ave.

VS 150

131a

G77328

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3 45

G77328

Registered No.

1. NAME OF DECEASED (Type or Print) **Sophie Pauline Simon Brown**

2. DATE OF DEATH **Aug.15/49**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **Baltimore, Md.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **General German Aged Peoples Home, 22 S. Athol Ave.**

c. Length of stay in Baltimore **75 yrs** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **22 S. Athol Ave.** 28-04

5. SEX **Female**

6. COLOR OR RACE **W.**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Widow**

8. DATE OF BIRTH **Feb 18,1866**

9. AGE (In years last birthday) **83** | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None**

10B. KIND OF BUSINESS OR INDUSTRY **none**

11. BIRTHPLACE (State or foreign country) **Germany**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Jabot Simon**

14. MOTHER'S MAIDEN NAME **Marie Widemann**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT **Mr.J. George Walz, 22 S. Athol Ave** ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Multiple Sclerosis.** — INTERVAL BETWEEN ONSET AND DEATH: **Unknown.**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* **June 1/49**, 19__, *to* **Aug.15/49**, 19__, *that I last saw the deceased alive on* **Aug.8/49** 19__ *and that death occurred at* **4.50 P.M.** *from the causes and on the date stated above.*

23A. SIGNATURE **Henry Walz Schmidt** M. D.

23B. ADDRESS **933 Hanover St. Balto.30, Md.**

23C. DATE SIGNED **Aug.16/49.**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24B. DATE **Aug.17/49**

24C. NAME OF CEMETERY OR CREMATORY **Salem Lutheran Cemty.**

24D. LOCATION (City, town, or county) (State) **Ingleside Ave. Catonsville**

DATE RECEIVED BY LOCAL REGISTRAR AUG 16 1949

REGISTRAR'S SIGNATURE **Huntington Williams, M.D.**

25. FUNERAL DIRECTOR **Harry A. Cissel**

ADDRESS **4101 Edmondson Ave.**

VS 150

87D

Please write the cause of death clearly and legibly. Physician: please write the exact age in especially important.

G77329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77329

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sarah M. Blackwell

2. DATE OF DEATH Aug. 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2034 Madison Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.

D. STREET ADDRESS (If rural, give location) 1408 N. Madison Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col.	Divorced	May 19, 1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher (Retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Myers

14. MOTHER'S MAIDEN NAME Ella Keyser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Jean Blackwell Razaf 2035 Druid Hill Ave

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G77330 CERTIFICATE CORRECTED 8-22-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 18

G77330 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES BODY MARTIN

2. DATE OF DEATH 8-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4216 Harford Terrace

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9 0 ✓

b. STREET ADDRESS (If rural, give location) 4216 Harford Terrace

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 Hours: Hours, Min.
male	white	married	Dec. 22 [illegible]	72 [illegible]		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Harford Co. Md.	

13. FATHER'S NAME August Martin

14. MOTHER'S MAIDEN NAME Anna Jane Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Lora A. Martin ADDRESS 4216 Harford Ter.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Urinary Bladder — INTERVAL BETWEEN ONSET AND DEATH 1 Year

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
May 1949	Carcinoma Bladder	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1945 *to* 8-15-, 1949, *that I last saw the deceased alive on* 8-8-, 1949 *and that death occurred at* 5:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. W. Peake M. D.	4508 Harford Road	8-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/19/49	St. Johns	Long Green Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williams (M)	Leonard Luck	5305 Harford Rd.

VS 150

52B

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77331

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77331

1. NAME OF DECEASED (Type or Print): Michael J. Farley

2. DATE OF DEATH: Aug. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2938 Clifton Park Terrace
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2938 Clifton Park Terrace

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	widowed	Jan. 21, 1871	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Michael J. Farley
14. MOTHER'S MAIDEN NAME: Annie Noel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Thomas Mc Donald, 2938 Clifton Pk Ter. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive CVD - heart failure
DUE TO
(B) Arteriosclerotic Heart Disease - Coronary Sclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/14, 1949 *to* 8/14, 1949 *that I last saw the deceased alive on* 8/14, 1949 *and that death occurred at* 9:55 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Israel W. Minter, M. D.
23B. ADDRESS: 3009 Evergreen Avenue
23C. DATE SIGNED: 8/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-17-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 15 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, 5305 Harford Road.

VS 150

931

Write the cause of death clearly and correct age is especially important. Physicians: please write this

G77332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G77332

1. NAME OF DECEASED (Type or Print): WILLIAM SAUNDERS MARKLEY | 2. DATE OF DEATH: 8/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4918 Grindon Ave.
c. Length of stay in Baltimore: Yrs. 27 Mos. 03 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland | B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4918 Grindon Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Nov. 2-1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	B.T. Co.	Greenwood Md	

13. FATHER'S NAME: Frederick Markley
14. MOTHER'S MAIDEN NAME: Louise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		218-09-9358B	Mrs Lydia Markley	4918 Grindon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 Mins.
DUE TO
(B) Myocarditis — 4 yrs.
DUE TO
(C) Arteriosclerosis Fibrillation

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 19[illegible] *to* 8/15 19 49, *that I last saw the deceased alive on* July 19 49, *and that death occurred at* 2:05 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter Hartman M. D.	4931 Harford Rd	8/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-18-49	Druid Ridge	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Hunter Washington Williams, M.D.	Leland J. Luck - 5305	Harford Rd.

VS 150

93E

Please write the cause of death clearly and legibly. Physician: please write in full. Do not abbreviate. Be sure that every item is complete and correct age is especially important.

G77333

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

416

Registered No. G77333

1. NAME OF DECEASED (Type or Print): George L King Sr.

2. DATE OF DEATH: 8-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq Hosp
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: BALTO
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. CATONSVILLE
D. STREET ADDRESS (If rural, give location): # 3 Merrell Rd

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 2-11-1889
9. AGE (In years last birthday): 60
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HANDYMAN
10B. KIND OF BUSINESS OR INDUSTRY: ODD JOBS
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lewis King
14. MOTHER'S MAIDEN NAME: Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-14-7849
17. INFORMANT: James King — ADDRESS: 321 S Gilmor St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: yrs
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-10, 1949 *to* 8-13, 1949, *that I last saw the deceased alive on* 8-13, 1949, *and that death occurred at* 7:40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. J. Lahan M. D.
23B. ADDRESS: Franklin Sq Hosp.
23C. DATE SIGNED: 8-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: Aug. 12 1949
24C. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL
24D. LOCATION (City, town, or county) (State): BALTO MD

DATE RECEIVED BY LOCAL REGISTRAR: AUG. 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: HARRY H [illegible] - 4101 EDMONDSON AVE

VS 150

95B

Please write the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and correct age is especially important.

Dr Walter Burk
Gifford Lager 60

G77334

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4r0.0

G77334 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Margaret Lunts**

2. DATE OF DEATH **August 16, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland** **Baltimore, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **1506 Mt. Royal Avenue**

c. Length of stay in Baltimore **35 years** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **1506 Mt. Royal Avenue** 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	April 24, 1855	94		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Pennsylvania	

13. FATHER'S NAME **Nicholas N. Miller**

14. MOTHER'S MAIDEN NAME **Christine Reebe**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no	no

17. INFORMANT **Frances Carroll** ADDRESS **4202 Charlcote Road**

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ca of head of pancreas with jaundice

DUE TO

(B) generalized arteriosclerosis & arteriosclerotic heart disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY Ooccur?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 7, 1949 *to* Aug 15, 1949, *that I last saw the deceased alive on* Aug 15, 1949, *and that death occurred at* 1:45 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter B. Burk M. D.	18 E. Eager St - 2	Aug 16, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
removal	8/16/49	Evans City Cemetery	Evans City, Pennsylvania

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 16 1949	Huntington Williams, Md	Wm. Cook, Inc., 1217 St. Paul Street

VS 150

937

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77335

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 011

G77335

Registered No.

1. NAME OF DECEASED (Type or Print) Ressie B. King

2. DATE OF DEATH Aug. 14th 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1302 W. Lexington St.
c. Length of stay in Baltimore Home of Our Lady 30 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 730 W. Fayette St. 4-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	White	Widowed	Aug. 30, 1894	54	11	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home Duties		Virginia	

13. FATHER'S NAME J. T. Bresden

14. MOTHER'S MAIDEN NAME Elizabeth Kline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	216-01-0075	Mrs S.R.Myers,	729 W. Fayette St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	J. [illegible] Rectal Fistula	14 Years
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Partial Intestinal Obstruction	7 Days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1947 *to* Aug 14, 1949, *that I last saw the deceased alive on* Aug 14, 1949, *and that death occurred at* 4 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry Glassman M. D.	753 W. Fayette St	8-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/16/49	Woodlawn	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williamson, M.D.	Fred. H. Vole	1200 W. Lombard St

VS 150

15

Please write the cause of death clearly and legibly. Physician: please write: correct age is especially important.

G77336 130888 BALTIMORE CITY HEALTH DEPARTMENT G77336

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frank Hopkins

2. DATE OF DEATH August 13, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 40 YEARS (Yrs. - Mos. - Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

d. STREET ADDRESS (If rural, give location) 1353 Whatcoat ST 15-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Widowed	OCT. 1874	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
COOK	PRIVATE FAMILY	Maryland	

13. FATHER'S NAME Frank Hopkins

14. MOTHER'S MAIDEN NAME Annie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Records Balto City Hospitals	Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Primary Metastatic Carcinoma of the Liver — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. arteriosclerosis generalized Hypertensive Cardio Vascular Disease

(or an)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-8-49, 19__, *to* 8-13, 1949, *that I last saw the deceased alive on* 8-13, 1949, *and that death occurred at* 3.45 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. S. Logan M. D.	4940 Eastern Ave	August 16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	8-17-49	Western Star	Catonsville — Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 16 1949	Huntington Williams, M.D.	Samuel W. Sullivan Jr.	46 E. 10 11 N. Arlington Ave

VS 150

PLEASE WRITE PLAINLY, with pen and ink, and state the cause of death clearly and correct age is especially important. Physician: please write the

G77337

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C.49-16422

CERTIFICATE OF DEATH

776

Registered No. G77387

1. NAME OF DECEASED (Type or Print): MARSHA LOUISE WILLIAMS

2. DATE OF DEATH: AUGUST 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
c. Length of stay in Baltimore: 1 ~~Yrs~~ ~~Mos~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 757 BRADLEY ST. 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	COLORED	SINGLE	AUGUST 7, 1949		1	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	NEWBORN	MARYLAND	U.S.A.

13. FATHER'S NAME: WALTER WILLIAMS

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* AUG 7, 1949 *to* AUG. 8, 1949 *that I last saw the deceased alive on* AUG 8, 1949 *and that death occurred at* 6:00 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edmund B. Middleton M. D.	UNIVERSITY HOSPITAL	August 9, '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL AUG 11 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

159

Please write the cause of death clearly and correct age is especially important. Physician:

G77338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77338

BIRTH NO. B.C. 49-16718

1. NAME OF DECEASED (Type or Print): JOAN ANN FERRARO

2. DATE OF DEATH: August 13, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctor's Hospital

c. Length of stay in Baltimore: 6 HOURS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2118 East Baltimore Street

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: August 13, 1949
9. AGE (In years last birthday): If Under 1 Year: Months / Days; If Under 24 Hours: Hours 6 / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAME FERRARO

14. MOTHER'S MAIDEN NAME: JOAN CLARA Elizabeth ~~JACOB~~ JACOB

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mother (MRS. J.C. FERRARO) ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) 6 hours (126 weeks)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-17, 1949 *to* 8-13, 1949, *that I last saw the deceased alive on* 8-13, 1949 *and that death occurred at* 9:45 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D.
23B. ADDRESS: 2730 N Charles
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL AUG 15 1949
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 150

159

GM. 79737

7339
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77339

1. NAME OF DECEASED (Type or Print): Joseph Kertin or Kevtis

2. DATE OF DEATH: 8- 1- 1949.

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: ? (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): No Home

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Mar. 19 1865
9. AGE (In years last birthday): 84
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Steve (D)
14. MOTHER'S MAIDEN NAME: Helena

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records Balto. City Hospital
ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO
(B) Hypertensive Arteriosclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE - (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2- 9- , 1943 to 8- 1 - , 1949, *that I last saw the deceased alive on* 8- 1 -1949, *and that death occurred at* 8 20Am *m., from the causes and on the date stated above.*

23A. SIGNATURE: H. S. Rogers M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 8- 9- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL AUG 11 1949
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

93D

Please write plainly. Physician: please write the cause of death clearly and legibly. Exact age is especially important.

G77340

BIRTH NO. 24448

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

Registered No. G77340

1. NAME OF DECEASED (Type or Print): George Smith

2. DATE OF DEATH: Aug. 1, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 109 Aisquith St. E-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Negro	Wid.	Feb. 9, 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Isaac Smith
14. MOTHER'S MAIDEN NAME: Fannie Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident.
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 8-7-49
19B. MAJOR FINDINGS OF OPERATION: Skin Graft
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-16, 1937, *to* Aug. 1, 1949, *that I last saw the deceased alive on* Aug. 1, 1949, *and that death occurred at* 7.30PM, *from the causes and on the date stated above.*

23A. SIGNATURE: J. A. Crozer M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 8-5-1949

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL AUG 9 1949
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: AUG 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

8 3a

G77341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 G77341

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) FRANK SMITH

2. DATE OF DEATH 26 JULY 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Hosp 17 N. Carey St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1713 Lancaster Street 2-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married		65?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic & Hypertensive cardio-vascular renal unit cardiac decompensation

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cachexia, severe, cause undetermined

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 15 June 1949 *to* 26 July, 1949, *that I last saw the deceased alive on* 26 July, 1949, *and that death occurred at* 6:30 P m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Emil H. Hemming Jr. M. D.	4580 Edmondson Ave	27 July 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL AUG 9 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Huntington Williams, M.D.	[illegible]	

VS 150

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

82.0921

93D

G77342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77342

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Wilbur L. Bishop

2. DATE OF DEATH July 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1124 Hamburg St. 21-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W			65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp& Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L. Royster M.D.
23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED July 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL AUG 9 1949
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR AUG 17 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS

VS 151

PLEASE WRITE PLAINLY. USE INK. Be sure to write the cause of death clearly and correct age is especially important. Physician: please write legibly.

94a

G77343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77343

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RAYMOND STANFORD

2. DATE OF DEATH July 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Found in truck S.E. corner of Baltimore and Front St. Mercy Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE UNKNOWN
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) UNKNOWN 5-1
D. STREET ADDRESS (If rural, give location) UNKNOWN

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C			50?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Tuberculous pneumonia	
ANTECEDENT CAUSES	DUE TO (B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George G. Merrill M.D.		7/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	AUG 9 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Huntington Williams, M.D.		

VS 151

PLEASE WRITE PLAINLY, WITH PENCIL OR INK. Be sure to write the cause of death clearly and legibly. Physician: please write correct age is especially important.

13 B

BS-27877

G77544

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

450.0 G77544

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Saunders

2. DATE OF DEATH 7-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospitals

c. Length of stay in Baltimore — Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 309 Fayette Street 4-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Married	?	67?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Saunders (D)	Jane Fillis (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		RECORDS*BALTO. CITY HOSPITALS	4940 EASTERN AVE.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please be especially important. Correct age is

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Broncho-pneumonia

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Generalized arteriosclerosis and emphysema

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-14 1945 *to* 7-31, 1949, *that I last saw the deceased alive on* 7-31 1949, *and that death occurred at* 1:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. S. Rogers M. D.	4940 Eastern Avenue	8-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	AUG 9 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 7 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

107

G77345 X ✓ 58.1 G77345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C. 49-16615

1. NAME OF DECEASED (Type or Print): Susan Patricia McCormick

2. DATE OF DEATH: August 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp for the Women of Maryland, Lafayette + John Sts. Baltimore, Maryland
c. Length of stay in Baltimore: 1 hour 55 min. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — Towson
D. STREET ADDRESS (If rural, give location): 2919 E. Joppa Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	August 11, 1949			1 / 55

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Maryland	U.S.A

13. FATHER'S NAME: Kenneth Winchester McCormick

14. MOTHER'S MAIDEN NAME: Clare Veronica Robb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Clare Veronica Robb.	2919 E Joppa Road Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Achondroplastic Dwarfism

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7:45 A.M. Aug 11, 1949, *to* 1:40 A.M. Aug 11, 1949, *that I last saw the deceased alive on* Aug 11, 1949, *and that death occurred at* 7:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Anna Fagelberg M. D.	Hosp for the Women of Maryland Baltimore Md.	Aug 11, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL AUG 16 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

159

Note the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G77346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

774

G77346

Registered No.

BIRTH NO. BC. 49-1641

1. NAME OF DECEASED (Type or Print): HAROLD BEAUCHAMP Boyd.

2. DATE OF DEATH: AUG 11, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO.
D. STREET ADDRESS (If rural, give location): 149 N. DECKER ST. 6-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	wh.	Single	AUG. 11, 1949.			3.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bath. Steel	Steel Worker	Md. Balt.	

13. FATHER'S NAME: Coleman McCue Boyd.

14. MOTHER'S MAIDEN NAME: Eleanor Marie Beauchamp.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pre-maturity — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs

DUE TO

(B) Pre-mature rupture of Membranes

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 8-11 19 49 *to* 8-11 19 49 *that I last saw the deceased alive on* 8-11 19 49, *and that death occurred at* 3 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George W. Borkowski M. D.	Franklin Sq. Hosp	8-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL AUG 16 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

160C

Correct age is especially important. Physician: please write the cause of death clearly and fully.

G77347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

G77347

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Anna G Campbell Ellicott

2. DATE OF DEATH August 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 714 St Paul St

c. Length of stay in Baltimore 50? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 714 St. Paul St 11-0 r

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	WIDOWED	1869	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Washington D.C

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John A. Campbell

14. MOTHER'S MAIDEN NAME: Ella Colston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Chas Ellis Ellicott ADDRESS 2405 Ruscombe Lane

MEDICAL CERTIFICATION

Please write the cause of death clearly and correct age is especially important. Physician: please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Colon — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease — 10 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 1, 1949, to August 16, 1949, *that I last saw the deceased alive on* August 15, 1949, *and that death occurred at* 6:50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Crawford W. Kirkpatrick Jr. M. D.

23B. ADDRESS: 6 E Eager St. Baltimore, Md.

23C. DATE SIGNED: August 16 '49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: Aug 18 1949

24C. NAME OF CEMETERY OR CREMATORY: Rock Creek

24D. LOCATION (City, town, or county) (State): Washington D C

DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Henry W Simmons Sons ADDRESS 4905 York Rd

VS 150

46E

G77348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77348
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Adelaide S Boyd

2. DATE OF DEATH Aug 16 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 101 W Monument St

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-0
D. STREET ADDRESS (If rural, give location) 101 W Mounment ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	W.	widowed	1866	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Balto. Md	

13. FATHER'S NAME Geo. Henry Streckelmeyer

14. MOTHER'S MAIDEN NAME Maria A Harnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	J Irvin McCourt	815 Mercantile Trust Bldg

MEDICAL CERTIFICATION

Physician: please write the cause of death clearly and correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure — Interval between onset and death: Immediate

DUE TO

(B) Chr. Myocarditis — Indefinite

DUE TO

(C) Generalized Arteriosclerosis — Indefinite

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1946, 19__, *to* Aug 16 1949 *that I last saw the deceased alive on* Aug 17, 1949, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathaniel M. Beck M. D.	100 E. 23rd St	Aug 17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	Aug 18 1949	Holy Redeemer	Balto., Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Hunterston Williams, M.D.	Henry W. Jenkins Sons Co	492 York Rd

VS 150

93D

G77349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. G77349

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Preston Skerrett

2. DATE OF DEATH 16 Aug 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 212 Stoney Run Lane

C. Length of stay in Baltimore 25 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE N.J.
B. COUNTY
C) CITY OR TOWN. (If outside corporate limits, write RURAL and give township) MAPLEWOOD
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	WIDOWED	Dec. 6, 1869	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	U.S.

13. FATHER'S NAME John F. Preston

14. MOTHER'S MAIDEN NAME Eliza Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT John F. Preston ADDRESS San Antonio Texas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral Vascular accident 5 mos

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Mar 1949 *to* Aug 16, 1949, *that I last saw the deceased alive on* 15 Aug, 1949, *and that death occurred at* 10:54 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul H Loyce M D M. D.	Rockville 8, Md.	16 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-18-1949	BALTO.	BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Huntington Williams, M.D.	H. W. JENKINS & SONS CO.	4905 YORK RD.

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

83a

G77350

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

#4 ✓ G77350 Registered No.

1. NAME OF DECEASED (Type or Print) Walter Carter

2. DATE OF DEATH 8-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp.

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1311 Harlem Ave. 16-0 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	M	Nov. 26, 1906	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) S. Carolina

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Moses Carter

14. MOTHER'S MAIDEN NAME Isabella Berry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Ellen Carter ADDRESS 1311 Harlem Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malignant Hypertension C.-V. Renal Disease
DUE TO
(B) C Uremia
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-13 1949 *to* 8-15 1949 *that I last saw the deceased alive on* 8-15 1949 *and that death occurred at* 8:5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE H. H. Smith Jr. M. D. | 23B. ADDRESS Univ. Hosp. | 23C. DATE SIGNED 8-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-19-49	Western Star	Catonsville Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 17 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Mrs. Frances A. Hemsley | ADDRESS 578 W. Biddle St

VS 150

AUG 17 1949

1312

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77351

BIRTH NO

1. NAME OF DECEASED (Type or Print): JOSEPH S. GOLDSTEIN

2. DATE OF DEATH: August 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3600 Reisterstown Road
c. Length of stay in Baltimore: 30 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3600 Reisterstown Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	MARRIED	Nov 14, 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
(RETIRED) ODD JOBS	RACE TRACK	New York	USA

13. FATHER'S NAME: Philip Goldstein

14. MOTHER'S MAIDEN NAME: Rose Gresheim

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Annie Goldstein	ADDRESS: 3600 Reisterstown Road

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute Coronary Thrombosis	15 min
ANTECEDENT CAUSES	DUE TO (B) arteriosclerosis - hypertension	years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1944, 19__, *to* 8/15/49, 19__, *that I last saw the deceased alive on* 8/15, 1949, *and that death occurred at* 1:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Theo B Kirk MD M. D.	2320 Eutaw Place	8/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burail	Aug 18/49	Hebrew Friendship	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Huntington Williams, M.D.	S. Levinson & Bros	1124-26 W. North Avenue

VS 150

94a

Please write the cause of death clearly and legibly. Physician's please write the correct age is especially important.

G77352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77352

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES E. ASHER

2. DATE OF DEATH Aug. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5506 Fair Oaks Avenue
c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5506 Fair Oaks Avenue 27-06

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 10, 1870
9. AGE (In years. last birthday) 79 — If under 1 Year: Months / Days — If under 24 hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegrapher, retired
10B. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John E. Asher
14. MOTHER'S MAIDEN NAME Mary C. McKinley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Edith S. Asher, ADDRESS 5506 Fair Oaks Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio-vascular disease — 1942 — Aug 1949
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ — NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 14, 1949 *to* Aug 14, 1949, *that I last saw the deceased alive on* Aug 14, 1949 *and that death occurred at* 2:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Albert Herrmann, M. D.
23B. ADDRESS 6804 Old Harford Rd.
23C. DATE SIGNED 8-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/17/49
24C. NAME OF CEMETERY OR CREMATORY Ebenezer
24D. LOCATION (City, town, or county) (State) Cha se, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 17 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS William Cook, Inc., 1217 St. Paul St.

VS 150

93D

Please write the cause of death clearly and legibly. Physician please be especially important. Exact age is especially important.

G77353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77353

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Hattie P. Thompson

2. DATE OF DEATH 8/15/49 11:55 A.M.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 210 E. Lafayette Ave

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto

D. STREET ADDRESS (If rural, give location) 210 E. Lafayette Ave 12-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	3/9/1862	87				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	Self	Balto. Md.	

13. FATHER'S NAME Ambrose Barickman

14. MOTHER'S MAIDEN NAME Sarah Pike

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No			Enda Mudert	210 E. Lafayette Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coleifii aortic Stenosis	Unknown
ANTECEDENT CAUSES	DUE TO (B) (prob) arteriosclerosis	Unknown
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Arthritis, Rheumatoid	10 years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1948, *to* 15 Aug, 1949 *that I last saw the deceased alive on* 14 Aug, 1949, *and that death occurred at* 11:55 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	2020 N. Charles St	16 Aug 49

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify)	24B. DATE	24C. NAME OF CEMETERY OR ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	8/17/49	Balto	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Huntington Williams, M.D.	Wm Cook Inc.	1217 St. Paul St.

VS 150

92C

correct age is especially important. Physician please write plainly.

CERTIFICATE CORRECTED 8-16-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77354

BIRTH NO. 77354

1. NAME OF DECEASED (Type or Print): MARY SLAYSMAN

2. DATE OF DEATH: August 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1720 Harford Road
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Widow	12/22/1867	81 77 82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Riley
14. MOTHER'S MAIDEN NAME: Elizabeth Owens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. May Wilms
ADDRESS: 2128 E. North Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia - nephrosis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Rye M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: August 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 17th 1949	Oak Lawn	Eastern Ave Rd

DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leo Gleeck
ADDRESS: 1703 Patterson Park Ave

VS 151

97

G77355

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77355

Registered No.

1. NAME OF DECEASED (Type or Print): BENNETT FIELDS

2. DATE OF DEATH: August 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1713 McCubbin Street 6-05

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH:

9. AGE (In years last birthday): 55 | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. : 5ml

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Private home

11. BIRTHPLACE (State or foreign country): Greenville

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: David Feild

14. MOTHER'S MAIDEN NAME: Villella Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Beatrice Laborde 1140 Druid Hill Ave ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

Autopsy, Inspection or Inquiry

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 8/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Aug 19-49

24C. NAME OF CEMETERY OR CREMATORY: Corner Carroll

24D. LOCATION (City, town, or county) (State): Greenville Del.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949

REGISTRAR'S SIGNATURE: Timothy Williams, M.D.

25. FUNERAL DIRECTOR: J. C. Bond ADDRESS: 558 Haltimore St. Baltimore 2, Md.

VS 151

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G77356

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77356

1. NAME OF DECEASED (Type or Print): Eleanor Greenwell

2. DATE OF DEATH: 8-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6420 Reisterstown Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Seton Institute
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - Catonsville
D. STREET ADDRESS (If rural, give location): 38 Mellor Ave., Catonsville, Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	white	married	7-14-88	61	1	2	4	55

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Catonsville, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Marion Hamilton
14. MOTHER'S MAIDEN NAME: Katherine Fisher
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: The Seton Institute, Balto. 15

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician: please write the correct age in especially important.)

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage, DUE TO rt. hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension, DUE TO — duration unknown

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Myocarditis. Involutional melancholia

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 15, 1949 to August 16, 1949, that I last saw the deceased alive on August 16, 1949, and that death occurred at 4:55 a.m., from the causes and on the date stated above.

23A. SIGNATURE: Wm A Quinn M. D.
23B. ADDRESS: Seton Institute
23C. DATE SIGNED: 8-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. 18, 1949
24C. NAME OF CEMETERY OR CREMATORY: St. Johns Cem.
24D. LOCATION (City, town, or county) (State): Ellicott City, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: ADDRESS: Easton Sons Catonsville Md.

VS. 150

830

✓ Medical Examiner

677357

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 49-12412 **CERTIFICATE OF DEATH** Registered No. 677357

1. NAME OF DECEASED (Type or Print): Carroll W. Thomas

2. DATE OF DEATH: Aug. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp
C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-03
D. STREET ADDRESS (If rural, give location): 1372 W. Pratt St

5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 6 | 18 | 49
9. AGE (In years last birthday): Under 1 Year: Months 1 Days 29; Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY:
13. FATHER'S NAME: Robt W. Thomas
14. MOTHER'S MAIDEN NAME: Carolyn F. Whetley ✓
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Carolyn F. Thomas 1372 W. Pratt St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Atelectasis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 14, 1949, *to* Aug. 16, 1949, *that I last saw the deceased alive on* Aug. 16, 1949 *and that death occurred at* 2:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Albert J. Weiss, M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 8-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8 | 18 | 49
24C. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cem
24D. LOCATION (City, town, or county) — (State): Balto Md
DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Robt C. & B. M. Walter
ADDRESS: Pratt & Fremont Sts

VS 150

OU FOR 107

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. It is especially important. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. correct age is especially important.

G77358

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77358

Registered No.

1. NAME OF DECEASED (Type or Print): FRANCES - SMITH

2. DATE OF DEATH: AUG. 17-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: BALTO. MD.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1817 FLEET ST.
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MD.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO.
D. STREET ADDRESS (If rural, give location): 1817 FLEET ST. 2-03

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 18-1875
9. AGE (In years last birthday): 74 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTO. MD.
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: JOHN STEMMER
14. MOTHER'S MAIDEN NAME: SUZZANE FELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: JOHN STEMMER ADDRESS: 1817 FLEET ST.

MEDICAL CERTIFICATION

(Correct age is especially important. Physicians: please write the cause of death clearly and legibly.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho-pneumonia — 3 days.
DUE TO
(B)
DUE TO
(C) Chronic Myocarditis — 5 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 12, 1949, *to* Aug. 17, 1949, *that I last saw the deceased alive on* Aug. 17, 1949, *and that death occurred at* 3:25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John V. Szczepicki M. D.
23B. ADDRESS: 1817 Fleet St.
23C. DATE SIGNED: 8-17-49

24A. BURIAL, CREMATION OR REMOVAL (Specify): Burial
24B. DATE: Aug. 19-1949
24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus
24D. LOCATION (City, town, or county) (State): Balto. City

DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. L. Fialkowski
ADDRESS: 2007 Eastern Ave

VS 150

93

G27359 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77359

1. NAME OF DECEASED (Type or Print) ALBERT ELLIS

2. DATE OF DEATH August 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital
c. Length of stay in Baltimore 8 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1810 Clifton Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	Widowed	March 10, 1859	90		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Mr. John H. Ellis ADDRESS 1810 Clifton Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED August 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	August 17, 1949	Arbutus Mem. Park	Baltimore Co. Md

DATE RECEIVED BY LOCAL REGISTRAR Aug 17 1949
REGISTRAR'S SIGNATURE Tuntington Williams, M.D.
25. FUNERAL DIRECTOR Holland Funeral Home ADDRESS 1631 Druid Hill Ave.

VS 151

93D

Please write the cause of death clearly and legibly. Physician: please write the exact age if important. Physician: please write the cause of death clearly and legibly.

GM. 130985

G77360

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

G77360

Registered No.

1. NAME OF DECEASED (Type or Print): Catherine Wolf

2. DATE OF DEATH: August 13- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. 65 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1322 McHenry ST. 19-03

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 24 1882
9. AGE (In years last birthday): 67 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: (D)
14. MOTHER'S MAIDEN NAME: (D)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records B.C.H. ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular Accident
DUE TO
(B)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8- 11-, 1949 *to* 8- 13-, 1949 *that I last saw the deceased alive on* 8- 13-, 1949 *and that death occurred at* 9.15 PM *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 8-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 17 1949
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Balto.
DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Chas A. Cole
ADDRESS: 1913 W. Baltimore St.

VS 150

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correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G77361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77361 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES LEWIS

2. DATE OF DEATH August 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 232 North Mount Street 19-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	colored	Single	July 20, 1890	59				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	COPPER TUBING	Baltimore	U.S.A.

13. FATHER'S NAME Hezikiak Lewis

14. MOTHER'S MAIDEN NAME Mary Francis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	217-20-7211	Jane Williams	232 N. Mount St

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE George G. Merrill M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED August 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/17/49	Mt. Auburn	Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 17 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Charles H. Harper ADDRESS 512 Edmondson Av. 93D

Please write the cause of death clearly and legibly. Physician: please note that correct age is especially important.

G77362 ✓ G77362

BIRTH NO. G77362

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No.

1. NAME OF DECEASED (Type or Print): Clara Stokes

2. DATE OF DEATH: 14 Aug. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 633 N. Woodyear St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 633 Woodyear St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md
D. STREET ADDRESS (If rural, give location): 320 N. Stricker St 19-01

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 7/27/1895
9. AGE (In years last birthday): 54 — If under 1 year: Months 0, Days 17; If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maid
10B. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (State or foreign country): S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Theo. Sheer

14. MOTHER'S MAIDEN NAME: Martha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 238-30-9358

17. INFORMANT: Talmadge Stokes — ADDRESS: 320 N. Stricker St

MEDICAL CERTIFICATION

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular Accident
DUE TO
(B) Hypertensive Cardio-Vascular Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? ~

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 15 Aug. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/18/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Zion
24D. LOCATION (City, town, or county) (State): Manning S. C.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas. H. Corbin — ADDRESS: 513 Fairmount Ave 937

VS 15

G77363 CERTIFICATE CORRECTED 8-22-49 ✓ 1 G77363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 434 Registered No. G77363

1. NAME OF DECEASED (Type or Print) WILLIAM YOUNG

2. DATE OF DEATH August 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital

c. Length of stay in Baltimore 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1914 Mosher Street 16-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	Single	July 26th	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter		Baltimore, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Young	Zemora Beale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Zemora B. Young,	1914 W. Mosher Street.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pulmonary edema.

DUE TO

(B) Cerebral edema.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Acute congestive cardiac failure

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

Autopsy, Inspection or Inquiry

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR	23C. DATE SIGNED
George G. Merrill M.D.		August 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 18/49	Mt. Auburn	Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Clayton Williams, M.D.	Wm Brooks	1463 N. Carey

VS

93E

Please write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

G77364

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77364

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Annie E. Garrigan

2. DATE OF DEATH: Aug. 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1126 Wilcox St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1126 Wilcox St

10-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Nov. 22, 1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home		

13. FATHER'S NAME: James Golden

14. MOTHER'S MAIDEN NAME: Annie Curran

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	Mr. Garrigan,	1126 Wilcox St

MEDICAL CERTIFICATION

Write the cause of death clearly and concisely. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Interval between onset and death: 1 hr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Aortic Stenosis — ?

DUE TO

(C) arteriosclerosis — ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 1947 *to* Aug 16, 1949, *that I last saw the deceased alive on* Aug 8, 1949; *and that death occurred at* 3:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
S. Silverfield	714 E. Preston	17 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 18, 1949	Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Thurlington Williams, M.D.	Rita Wiedefeld	900 East Biddle St

94a

G77365

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77365

Registered No.

1. NAME OF DECEASED (Type or Print): Ella Williams ~~Murphey~~

2. DATE OF DEATH: Aug. 15 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 520 N. Paca St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 520 N. Paca St. 12-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	July 16 1852	97	1	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife	home	Salisburg Md?	U.S.

13. FATHER'S NAME: ? Murphey

14. MOTHER'S MAIDEN NAME: Rachel ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Mrs. Mary E. Bonanni 520 N. Paca St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pneumonia	2 days
	DUE TO Arterio sclerotic cardia vascular disease	Long
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C) Senility	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1940, *to* August 15, 1949 *that I last saw the deceased alive on* 8/13/49, 19__, *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	1901 Eutaw Place, City	8/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 17/49	Holy Redeemer Cem.	4430 Belair Rd. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 1949

REGISTRAR'S SIGNATURE: [signature] Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Frank Della Rose — ADDRESS: 722 S. High St.

VS 150

93D

Please write the cause of death clearly and completely. Physician: please write the cause of death clearly and completely. Physician: please write the cause of death clearly and completely.

G77366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77366 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mae M. Quade -McLeod

2. DATE OF DEATH: 8-15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland ~~Sinai Hospital~~ Monument and Rutland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3101 Foster Ave. 1-1

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: August 24, 1895
9. AGE (In years last birthday): 53
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): St. Mary's Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander Quade

14. MOTHER'S MAIDEN NAME: Madora Dean

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): --
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: --

17. INFORMANT: M. Frances Nielsen; ADDRESS: 632 N. Streeper St.

MEDICAL CERTIFICATION

Write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia & Empyema DUE TO Peritonitis

(B) DUE TO Septicemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) ASHD

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-9 19 49 to 8-15 19 49 *that I last saw the deceased alive on* 8-15 19 49 *and that death occurred at* 10 45 A. m.; *from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Katz M. D.
23B. ADDRESS: Sinai Hosp
23C. DATE SIGNED: 8-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8- - 49.
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): 7225 Eastern Ave Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Charles S. Zeiler
ADDRESS: 901 S. Conkling St.

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G77367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

581.0 G77367

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Heffner

2. DATE OF DEATH: 8/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1824 Byrd Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1824 Byrd Street 24-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	2/14/1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Inspector	Locke Ins. Co.	Germany	U.S.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Family - Same	

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cirrhosis of the Liver	8 months
DUE TO	(B) - Ascitis	3 months
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	- Arteriosclerosis	8 mos.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
None		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 5, 1947 *to* Aug 16, 1949, *that I last saw the deceased alive on* Aug 14, 1949, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. B. Mebb M. D.	1229 Fulton Ave	8/17/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	8/20/49	Cedar Hill	Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Huntington Williams, M.D.	James L. McCully	130 E. Fort Ave.

VS 150

124B

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Exact age is especially important.

G77368 G77368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) William C. Mosby Reynolds

2. DATE OF DEATH 8-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospt.

c. Length of stay in Baltimore 18 YEARS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2512 Arunah Ave. 16-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	MARRIED	11-14-1895	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CAR DISTRIBUTOR	B. & O. R.R.	PENNA.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Jacob Reynolds	Alice Walker.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO.			Mrs. Ida M. Reynolds	2512 Arunah Ave. 16

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.)

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion.

DUE TO

(B) Arteriosclerotic Coronary Heart Disease.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August 9th, 1949, *to* August 17, 1949, *that I last saw the deceased alive on* August 17, 1949, *and that death occurred at* 3.30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. J. Castellano M. D.	Bon Secours Hosp.	8-17-49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	8/19/49	Myersdale, Pa.	Myersdale, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 19 1949	Washington Williams, M.D.	WM. J. TICKNER & SONS INC.	North & Pa. Aves. Balto. 17, Md.

94a

G77369 ✓ G77369

BIRTH NO. G77369 B.C. 9-1930

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Linda Lee Miller

2. DATE OF DEATH: 8/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. 6 mo Mos. Days.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-06
D. STREET ADDRESS (If rural, give location): 1611 N Caroline St

5. SEX: Fe
6. COLOR OR RACE: N
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): sing/e
8. DATE OF BIRTH: 8/16/49
9. AGE (In years last birthday) If Under 1 Year: Months / Days; If Under 24 Hours: Hours 6 / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N'Born
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Eddie Miller
14. MOTHER'S MAIDEN NAME: Ann Estelle Coffey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Ann Miller ADDRESS: 1611 N Caroline St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxia pallida. —
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 16 1949 to Aug 16, 1949 *that I last saw the deceased alive on* Aug 16, 1949, *and that death occurred at* 11 10 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter T. Waddell M. D.
23B. ADDRESS: 766 Hamilton Ave
23C. DATE SIGNED: 8/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 17-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): A. A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949
REGISTRAR'S SIGNATURE: Washington Funeral Home, Md
25. FUNERAL DIRECTOR ADDRESS: Rayner Sanders 1412 E. Preston St 161a

VS 150

Please write the cause of death clearly and legibly. Physician's: please write the correct age is especially important.

G77370

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77370

Registered No.

Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

1. NAME OF DECEASED (Type or Print) Mr. Sydney Jacob Ross

2. DATE OF DEATH 8-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3311 Bancroft Road 27-W

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	W	Married	July 8, 1874	75 74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kay Jewelry Co. Manager
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jacob Ross
14. MOTHER'S MAIDEN NAME Minnie Wolfner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 21-20-8791
17. INFORMANT ~~Wife~~ Burdis S. Ross **ADDRESS** RR 3311 Bancroft

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarction
DUE TO
(B) Coronary occlusion
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cerebro-vascular accident, old, with Necrosis and softening, left cerebral hemisphere

INTERVAL BETWEEN ONSET AND DEATH 3 days

19A. DATE OF OPERATION — **19B. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — **21B. PLACE OF INJURY** (e. g., in or about home, farm, factory, street, office bldg., etc.) — **21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — **21E. INJURY OCCURRED** WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — **21F. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* Aug. 14, 1949 *to* Aug. 17, 1949, *that I last saw the deceased alive on* Aug. 17, 1949, *and that death occurred at* 1:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE John L. Green, JR M. Dr. — **23B. ADDRESS** Union Memorial Hosp. — **23C. DATE SIGNED** 17 Aug 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — **24B. DATE** Aug 19/1949 — **24C. NAME OF CEMETERY OR CREMATORY** Ohab Shalom Cemetery — **24D. LOCATION** (City, town, or county) O'Donnel St (State)

DATE RECEIVED BY LOCAL REGISTRAR AUG 17 1949 — **REGISTRAR'S SIGNATURE** Hunterington Williams, MD — **25. FUNERAL DIRECTOR** David Sonnheimer — **ADDRESS** 1902 Eastern Ave

VS 150

94a

G77371 CERTIFICATE CORRECTED 11-2-49 G77371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN BARNES

2. DATE OF DEATH August 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1603 Clifton Avenue 15-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	~~Married~~ Widower	May 12, 1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter

10B. KIND OF BUSINESS OR INDUSTRY: PENNA. R.R.

11. BIRTHPLACE (State or foreign country): St. Marys Co, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Barnes

14. MOTHER'S MAIDEN NAME: Laura Barnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 717-09-3709

17. INFORMANT: Wm. A. Barnes — ADDRESS: 3218 Barclay St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 8-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 18, 1949	Family Lot	Scotland-St. Marys Co, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949

REGISTRAR'S SIGNATURE: Dorothy Tom Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Gibson Funeral Home-1735 D.F.Ave.

VS 45-1

93D

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G77372

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77372 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Caspari Wylie

2. DATE OF DEATH 8/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 2508 Queen Anne Road

c. Length of stay in Baltimore Yrs. Life Mos. Days 15-09

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 2508 Queen Anne Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Jan-13-1893	56-7-3				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer
10B. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Edgar Wylie
14. MOTHER'S MAIDEN NAME Mattie Caspari
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 212-05-6758
17. INFORMANT Mrs. Jos. Payne, ADDRESS 4900 Wilmslow Road

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH 1½ years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection-Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE John R. Lewis, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED 8/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 18/49
24C. NAME OF CEMETERY OR CREMATORY London Park
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR AUG 18 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Stewart & Mowen Co. ADDRESS 108 W. North Ave
94a Balto. 1, Md.

VS 151.

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

334

G77373

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rosa Pohl Schell

2. DATE OF DEATH Aug-16-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 14 Merrymount Rd
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at home
c. Length of stay in Baltimore 23 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-13
D. STREET ADDRESS (If rural, give location) 14 Merrymount Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widow	Dec 29 1860	88 yrs	—	—	—	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Baltimore	U.S.

13. FATHER'S NAME Anton Pohl

14. MOTHER'S MAIDEN NAME Emilie Goering

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	None	Miss Doetsch	Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized and cerebral arteriosclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Terminal pneumonia

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1947, 19__, *to* Aug 15, 1949 *that I last saw the deceased alive on* Aug 15, 1949, *and that death occurred at* 5:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter B. Buch M. D.	18 E. Eager St - 2	Aug 17, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 19-49	Loudon Park	Balto.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Huntington Williams, M.D.	Stewart & Morris Co.	Balto.

97

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

CERTIFICATE CORRECTED 9-2-49

G77374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77374

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Charles Carroll Fulton Leser

2. DATE OF DEATH: 8/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4403 Bedford Place

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 4403 Bedford Place

27-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	divorced	July 27, 1900	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Artist		Co. Balto., Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Oscar Leser	Annette Agnus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W.W. 1 and 2		Judge Oscar Leser	4403 Bedford Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Vascular Disease

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Chronic Alcoholism

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
John R. Davis, M.D.		8/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 18, 1949	Druid Ridge Cemetery	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Huntington Williams, M.D.	John O. Mitchell Sons	1900 Eutaw Place

VS 151

94a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77375 G77375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BROWN, MARGARET

2. DATE OF DEATH: 8-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSP.

c. Length of stay in Baltimore: 3 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balto
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Lansdowne (Rural)
D. STREET ADDRESS (If rural, give location):

5. SEX: F. 6. COLOR OR RACE: W 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): UNMARRIED

8. DATE OF BIRTH: Aug 4 1898 9. AGE (In years last birthday): 51 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework 10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert M Rook

14. MOTHER'S MAIDEN NAME: Lennie Le Compte

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: E. Earl Brown ADDRESS: Lansdowne Md

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cachexia
DUE TO
(B) Carcinoma of stomach
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 11-9-48
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of cervix Inflammatory cell
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-15, 1949 *to* 8-17, 1949 *that I last saw the deceased alive on* 8-17, 1949, *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John W. Brown M. D.
23B. ADDRESS: Lansdowne Md.
23C. DATE SIGNED: 8-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 20 1949
24C. NAME OF CEMETERY OR CREMATORY: Fort New Market
24D. LOCATION (City, town, or county) (State): Ft. New Market, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 17 1949
REGISTRAR'S SIGNATURE: Catherine Hollander, M.D.
25. FUNERAL DIRECTOR: W. Leslie Broadbay ADDRESS: Lansdowne Md

VS 150

48a

Write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G77376 BALTIMORE CITY HEALTH DEPARTMENT G77376

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) McHugh, James J. — 2. DATE OF DEATH 8-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md — B. COUNTY Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1620 Linden Ave 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	8/17/49	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF (What country?)
Motor Reader	Gas & El Co	Cumberland, Md	U.S.A.

13. FATHER'S NAME James J McHugh — 14. MOTHER'S MAIDEN NAME Mabel Crawford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Frances Elmira McHugh — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Septicemia — Interval between onset and death: ?
DUE TO
(B) Liver disease — ?
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-6- 1949 *to* 8-17, 1949, *that I last saw the deceased alive on* 8-17, 1949, *and that death occurred at* 6:00 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D. — 23B. ADDRESS Univ Hosp. — 23C. DATE SIGNED 8-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/20/49	Loudon Park	Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE [signature] — 25. FUNERAL DIRECTOR John J. Cannon — ADDRESS

AUG 17 1949

125B

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

AB-72656 G77577 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G77577

BIRTH NO.

CERTIFICATE OF DEATH

331

1. NAME OF DECEASED (Type or Print) Edward Joyce

2. DATE OF DEATH August 14-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1700? Aliceanna St. 2-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	Sept- 27- 1872	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Maryland	

13. FATHER'S NAME Michael (D

14. MOTHER'S MAIDEN NAME Margaret (D

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT'S ADDRESS Baltimore City Hospitals Records: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-19- , 1942 *to* 8-14- , 1949, *that I last saw the deceased alive on* 8-14- , 1949 *and that death occurred at* 4 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. S. Logan M. D.	4940 Eastern Ave. Baltimore City Hospitals	Aug. 16-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	April 18 1949	Oak Lawn	Eastern Ave Road

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 17 1949	Twitington Williams, M.D.	John C. Moran	3000 E Baltimore

83a

Correct age is especially important. Physicians: please write the cause of death clearly and completely.

Hospital Disposal B.C. 49-7856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

60-5

Registered No. G77378

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby "Girl" Zappe "1"

2. DATE OF DEATH: AUG 5 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-8
D. STREET ADDRESS (If rural, give location): 2303 Garrett Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White		8-4-49	0			9	25

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Zappe.	Ethel Z. ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-4, 1949, *to* 8-5, 1949, *that I last saw the deceased alive on* 8-5, 1949, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William W. Mann M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Holy Disposal	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 10 1949	Huntington Williams, M.D.		

VS 150

160C

Correct age is especially important. Physician: please write the

G77379

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

116

G77379

Registered No.

1. NAME OF DECEASED (Type or Print): Elwood Deedon

2. DATE OF DEATH: 8-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq Hosp.

c. Length of stay in Baltimore: 10 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt. 19-3
D. STREET ADDRESS (If rural, give location): 1408 W. Lemon St

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Mar. 19-1918
9. AGE (In years last birthday): 31 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinists
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Centerville Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Winston Deedon
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.:

17. INFORMANT: Roalee Deedon ADDRESS: 1408 W. Lemon St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1949, *to* 8-11, 1949, *that I last saw the deceased alive on* 8-11, 1949, *and that death occurred at* 3 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. J. Luhum M. D.
23B. ADDRESS: Franklin Sq. Hosp.
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: aug 18-49
24C. NAME OF CEMETERY OR CREMATORY: Balto. Nat. Cem.
24D. LOCATION (City, town or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas O. Wilson ADDRESS: 1000 Bentalou

VS 150

95R

G77380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

G77380

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) WALTER T. GOSNELL

2. DATE OF DEATH 8/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 403 W. 23rd St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore
B. COUNTY Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 403 W. 23rd St. 12-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	12/24/1868	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Retired) CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Gosnell

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —

16. SOCIAL SECURITY NO. 24-14-3218

17. INFORMANT George Gosnell ADDRESS 403 W. 23rd St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure

DUE TO

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1949 *to* August, 1949, *that I last saw the deceased alive on* Aug 12, 1949, *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

23A. SIGNATURE A Weiss M. D.

23B. ADDRESS 2902 Huntington Ave.

23C. DATE SIGNED 8/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/19/49

24C. NAME OF CEMETERY OR CREMATORY Baltimore

24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 18 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wilhorn & Son ADDRESS 1214 Druid Hill Ave

VS 150

937

Please write the cause of death clearly and legibly. Physician's signature is especially important. Please write the exact age.

G77581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77581

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALFRED ELLING

2. DATE OF DEATH: August 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-4
D. STREET ADDRESS (If rural, give location): 1903 Jefferson Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Separated	Feb 3. 1885	64 63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Male Nurse Unemployed
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Herman Elling
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Linita Gerhart ADDRESS: 1654 Shadyside Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 8/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/20/49	Woodlawn Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Wilson Rose ADDRESS: 2114 East St

VS 151

937

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

G77382 MALOY 81.0 G77382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William H Maloy

2. DATE OF DEATH August 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore 64 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-14
D. STREET ADDRESS (If rural, give location) 3080 Overhill Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	10-12-1874	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Rev. C. Maloy
14. MOTHER'S MAIDEN NAME Margaret Hopkins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hemorrhage from	15 min
DUE TO	(B) esophageal varices	
DUE TO	(C) Cirrhosis of the liver	1 yr
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* 8-14, 1949, *to* 8-16, 1949, *that I last saw the deceased alive on* 8-16, 1949, *and that death occurred at* 750 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Ernest C. Brown Jr. M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 9/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/19/49
24C. NAME OF CEMETERY OR CREMATORY Druid Mount
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 18 1949
REGISTRAR'S SIGNATURE Deputy for Williams, M.D.
25. FUNERAL DIRECTOR Wilson & Son, Inc.
ADDRESS 1217 Eutaw St

VS 150

1243

Please write the correct age is especially important. Physician: please write the

G77383

BIRTH NO.

Dr Zimmerman 2838 Harford Rd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77383

Registered No.

1. NAME OF DECEASED (Type or Print): MARGARET L. PLUMMER

2. DATE OF DEATH: Aug. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Beech Hill Nursing Home, 6028 Old Harford Road
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-3
D. STREET ADDRESS (If rural, give location): 2703 N. Calvert St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	Feb. 10, 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress, retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Centreville, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas H. Plummer
14. MOTHER'S MAIDEN NAME: Margaret Glanding
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Maude M. Plummer
ADDRESS: 2703 St. Paul St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Arteriosclerotic Cardio-Vascular Disease — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 August, 1949 *to* 17 Aug., 1949 *that I last saw the deceased alive on* 16 Aug., 1949 *and that death occurred at* 3:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lee M. Zimmerman M. D.
23B. ADDRESS: 2838 Harford Rd.
23C. DATE SIGNED: 17 Aug. 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/19/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 18 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: William Cook, Inc.
ADDRESS: 1217 St. Paul St.

VS 150

93D

G77384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

G77384

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) JONAS ARONSON

2. DATE OF DEATH 8-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1806 Morland Ave

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-3
D. STREET ADDRESS (If rural, give location) 1806 Morland Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married		47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
self	Junk	Balto Md	

13. FATHER'S NAME Max

14. MOTHER'S MAIDEN NAME Dora

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Tillie Aronson	1806 Morland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brochogenic Carcinoma

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Nov. 2 1949	Inoperable.	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 1944 *to* Aug 17, 1949 *that I last saw the deceased alive on* Aug 17, 1949 *and that death occurred at* 12:55 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry A Dine M. D.	118 Biggs St	Aug 18 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-19-49	Hebrew Hebrew Mem	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 18 1949	Huntington Williams, M.D.	Jack Levin Inc	2100 Eutaw Pl

VS 150

47C

G77385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77385 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr. Arthur Marder

2. DATE OF DEATH: 8-18-49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale
C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-4
D. STREET ADDRESS (If rural, give location): 3002 Archerdale Terrace

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married		40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electro Plater	SELF	Montreal Can	

13. FATHER'S NAME: David

14. MOTHER'S MAIDEN NAME: Rebecca

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Gertrude Marder.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Amyotrophic lateral sclerosis + bulbar involvement — INTERVAL BETWEEN ONSET AND DEATH: about 1½ year

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 11, 1949 *to* August 18, 1949, *that I last saw the deceased alive on* 8-18, 1949, *and that death occurred at* 12 45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Berone Joachim Blumtog M. D.	Levindale Home	8-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-19-49	Hebrew Young Mens	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 18 1949	Huntington Williams, M.D.	Joel Lewis Inc	2100 Eutaw Pl

VS 150

82

G77386

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

S 4 0.0 G77386

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Poiley

2. DATE OF DEATH 8/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

c. Length of stay in Baltimore 45 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-9
D. STREET ADDRESS (If rural, give location) 3915 Norfolk Avenue

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH March IO 1881
9. AGE (In years last birthday) 68 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet- Maker
10B. KIND OF BUSINESS OR INDUSTRY CASKET COMPANY
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME UNKNOWN
14. MOTHER'S MAIDEN NAME UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Vera Poiley ADDRESS 3915 Norfolk Avenue

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hemorrhage
DUE TO
(B) Bleeding Peptic Ulcer
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/17, 1949, *to* 8/17, 1949, *that I last saw the deceased alive on* 8/17, 1949, *and that death occurred at* 6:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE Isaac Miller M. D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 8/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/18/49
24C. NAME OF CEMETERY OR CREMATORY Hebrew Young Mens
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25. FUNERAL DIRECTOR S. Levinson & Bros ADDRESS 1124-28 W North Avenue

DATE RECEIVED BY LOCAL REGISTRAR AUG 18 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.

VS 150

117a

Please write the cause of death clearly and legibly. Physician: please write the correct age in years. It is especially important.

G77387

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77387

BIRTH NO.

1. NAME OF DECEASED (Type or Print) THOMAS BRAXTON

2. DATE OF DEATH August 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital
C. Length of stay in Baltimore 35 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-5
D. STREET ADDRESS (If rural, give location) 1712 Brentwood Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Married	3/20/99	49 50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed
10B. KIND OF BUSINESS OR INDUSTRY LABORER - ODD JOBS
11. BIRTHPLACE (State or foreign country) Richmond, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Braxton
14. MOTHER'S MAIDEN NAME Alice Thompkins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) W.W.I
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Estelle Braxton ADDRESS 1712 Brentwood

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Degeneration
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY occur?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 8-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/19/49
24C. NAME OF CEMETERY OR CREMATORY Baltimore National
24D. LOCATION (City, town, or county) (State) Baltimore Md
DATE RECEIVED BY LOCAL REGISTRAR AUG 18 1949
REGISTRAR'S SIGNATURE Curtis Jon Williams, M.D.
23. FUNERAL DIRECTOR, ADDRESS Charles L. Law 802 Mad Ave.

VS 151

Please write the cause of death clearly and legibly. Physician: please write age is especially important.

G77388

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77388

Registered No.

1. NAME OF DECEASED (Type or Print): HARRY PHILIPPI

2. DATE OF DEATH: Aug. 17th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland St. Joseph's Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: 67 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 5515 Omaha Ave. 26-2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	April 20th, 1871	78	3	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Farmer		Germany	

13. FATHER'S NAME: Nicholas Philippi

14. MOTHER'S MAIDEN NAME: Christina Sinsz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Mrs. Harry Philippi	5515 Omaha

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G77389

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77389

1. NAME OF DECEASED (Type or Print): Fred or Ferdinando Di Marco.

2. DATE OF DEATH: August 16 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 612 N. Clinton St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 26 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-10
D. STREET ADDRESS (If rural, give location): 612 N. Clinton St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	March 8 1898	51	5	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pipe Mill	Bet. Steel Co.	Teramo Italy	U.S.

13. FATHER'S NAME: Pasquale Di Marco

14. MOTHER'S MAIDEN NAME: Adelaide Campanella

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-09-2076

17. INFORMANT: Josephine Di Marco ADDRESS: 612 N. Clinton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary oedema

DUE TO

(B) Cardiac Decompensation.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Carcinoma Stomach -

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: July 6, 1949

19B. MAJOR FINDINGS OF OPERATION: Empyema Gall Bladder - Carcinoma Stomach

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1949, *to* Aug 16, 1949, *that I last saw the deceased alive on* Aug 16, 1949 *and that death occurred at* 10:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Melvin J. Lamonica M. D.

23B. ADDRESS: 2911 Eastern Ave.

23C. DATE SIGNED: Aug 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	August 19 1949	Holy Redeemer Cem.	4430 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Gould Della Woee ADDRESS: 322 S. High St.

VS 150

46 B

G77390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77390

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Michael Sudina

2. DATE OF DEATH: Aug. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3709 W. GARRISON Ave.

c. Length of stay in Baltimore: 57 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township) MD. 27-18
D. STREET ADDRESS (If rural, give location): 3709 W. GARRISON Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	MARRIED	1867	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10B. KIND OF BUSINESS OR INDUSTRY: SELF

11. BIRTHPLACE (State or foreign country): Europe

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Sudina

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Helen Sudina ADDRESS: 3709 W. GARRISON Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: About 2 yrs

DUE TO

(B) Generalized Arterio Sclerosis — About 3 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Chronic Bronchitis — About 10 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(2) Right Side Hemiplegia — One year

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* February 1948 *to* Aug. 16, 1949 *that I last saw the deceased alive on* Aug 10th, 1949 *and that death occurred at* 7:50 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Julius C. Bluck, M. D.

23B. ADDRESS: 5356 Reisterstown Rd.

23C. DATE SIGNED: 8/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: Aug. 20, 1949

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Philip E. Brach ADDRESS: 902 N. Chester St.

VS 150

93D

77391

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 41.7.3

G77391 Registered No.

1. NAME OF DECEASED (Type or Print): Jessie Smith — N-862.2

2. DATE OF DEATH: august 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: 15 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-2
D. STREET ADDRESS (If rural, give location): 534 Oxford St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	S		55				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: American Paving Co
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown —
14. MOTHER'S MAIDEN NAME: Unknown —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Louie Thomason ADDRESS 534 Oxford St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Crushed Chest
DUE TO
(B) Amputation of left arm
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Factory
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): American Paving Company 2525 Loch Raven Blvd.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 8/16/49 10 A. m.
21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Pulled into machine by power belt 9/8

22. *I certify that I took charge of the remains described above, held an* Inspection & In. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl L Kroger M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: August 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/20/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): B. A. Co., Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: D. L. Brown & Son ADDRESS 108 W Monument St

VS 151

176

Please write the cause of death clearly and legibly. Correct age is especially important. Physicians: please write

G77392

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

445

G77392

Registered No.

1. NAME OF DECEASED (Type or Print): WALLACE E. KENT

2. DATE OF DEATH: 8-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: 6 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore I7,
D. STREET ADDRESS (If rural, give location): I327 Upton Street 17-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
Male	Colored	Single	9-23-I908	40	I0	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Maryland	

13. FATHER'S NAME: Daniel Kent

14. MOTHER'S MAIDEN NAME: Julia Gantt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Letha Herring ADDRESS: I327 Upton Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malignant Hypertension

DUE TO

(B)

DUE TO

(C) Uremia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-11 *, 19*49 *to* 8-16 *, 19*49 *, that I last saw the deceased alive on* 8-16 *, 19*49 *, and that death occurred at* 2:10 *m., from the causes and on the date stated above.*

23A. SIGNATURE: L. E. Brady M. D. | 23B. ADDRESS: Provident Hospital | 23C. DATE SIGNED: 8-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-19-49.	MT. AUBURN	BALTIMORE, MD.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. A. JACKSON - ADDRESS: 916 PENNA. AVE.

VS 150

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G77393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

196 Registered No. G77393

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD WALTER RADOMSKI

2. DATE OF DEATH 8/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General
C. Length of stay in Baltimore Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) 1-3
D. STREET ADDRESS (If rural, give location) 2618 Fait Ave #2

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH Sept 16-31 | 9. AGE (In years last birthday) 18 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Helper
10B. KIND OF BUSINESS OR INDUSTRY MACHINE SHOP
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Walter Radomski
14. MOTHER'S MAIDEN NAME Frances Więczynski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Frances Radomski ADDRESS 918 Woodlyn Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Metastatic Carcinoma
DUE TO
(B) Astrogenic Sarcoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 8/17/49
19B. MAJOR FINDINGS OF OPERATION Numerous metastases throughout chest
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/31 1949 to 8/17, 1949 that I last saw the deceased alive on 8/17, 1949 and that death occurred at 1:20 m. from the causes and on the date stated above.

23A. SIGNATURE Carl J. Blank M. D.
23B. ADDRESS Maryland General
23C. DATE SIGNED 8/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 20-49
24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary
24D. LOCATION (City, town, or county) (State) Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR AUG 18 1949
REGISTRAR'S SIGNATURE Huntington Williams, Jr.
25. FUNERAL DIRECTOR Wm. S. Fialkowski ADDRESS 2007 Eastern Ave

55B

• Correct age is especially important. Physician: please write

G77394 | BALTIMORE CITY HEALTH DEPARTMENT | G77394

BIRTH NO. G77394

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Clarence Jones

2. DATE OF DEATH: August 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-6
D. STREET ADDRESS (If rural, give location): 3504 Hickory Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	MARRIED	FEB. 26 1918	31		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FORGER	BALMAR CORP.	MARYLAND	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM H. JONES	MARGARET RUDASILL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	2nd W.W.	213-05-0455	GLADYS V. JONES	3504 HICKORY AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [✓], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
W. J. McCafferty M.D.		August 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 19/49	Baltimore National Cem	Frederick Road, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 18 1949	Huntington Williams, M.D.	Eustis E. Donovan	3818 Roland Ave

94a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77395

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 G77395

Registered No.

1. NAME OF DECEASED (Type or Print) WILLIE KROWSE

2. DATE OF DEATH 8/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore ~~Yrs.~~ ~~Mos.~~ 1 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pa.
B. COUNTY
C. CITY OR TOWN Delta (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	M	1887	62	-	-	-	-

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farmer-self	Pa.	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Krowse	Susan McConkey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N		-	Wife	Delta Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive arteriosclerotic cardiovascular disease

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/12/ 1949 *to* 8/18/ 1949, *that I last saw the deceased alive on* 8/18/ 1949, *and that death occurred at* 9:50 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. J. Treadwell M. D.	University Hospital	8/18

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-21-49	Mrs. Kenders	York Co. Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 18 1949	Irvington Williams M.D.	E. P. Forbes	Delta Pa

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G77396

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77396 Registered No. 151

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ISABELLA LOVETTE

2. DATE OF DEATH: 8/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 421 S. BOND ST.

C. Length of stay in Baltimore: UNKNOWN (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 3-1
D. STREET ADDRESS (If rural, give location): 421 S. BOND ST.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: 3/8/1893
9. AGE (In years last birthday): 56
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): EUROPE
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN NORWICK

14. MOTHER'S MAIDEN NAME: ISABELLA ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: EMIL J. R. LOVETTE
ADDRESS: 2733 E. MONUMENT ST. BALTO. MD.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARCINOMA OF STOMACH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: SINCE DEC 18, 1947

19A. DATE OF OPERATION: JAN-MARCH 1948
19B. MAJOR FINDINGS OF OPERATION: CARCINOMA OF STOMACH
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 23, 1948 *to* Aug. 15, 1949, *that I last saw the deceased alive on* Aug 15, 1949, *and that death occurred at* 1245 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph F. Arenga M. D.
23B. ADDRESS: 209 N Chester St
23C. DATE SIGNED: 8/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 8/20/1949
24C. NAME OF CEMETERY OR CREMATORY: HOLY REDEEMER
24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: LILLY & ZEILER
ADDRESS: BALTO. MD.

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G77397 ✓ G77397

BIRTH NO. G77397

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No.

1. NAME OF DECEASED (Type or Print): MARTIN JOHN MOLONEY

2. DATE OF DEATH: 8/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 713 S. POTOMAC ST.
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 1-1
D. STREET ADDRESS (If rural, give location): 713 S. POTOMAC ST.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 1/27/1880
9. AGE (In years last birthday): 69 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER
10B. KIND OF BUSINESS OR INDUSTRY: TUGBOAT
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM E. MOLONEY
14. MOTHER'S MAIDEN NAME: ? C. CLAREY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: GERTIE MOLONEY ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral accident. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Hypertensive Cardio-vascular disease.
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 8 1947 *to* 8-15 1949, *that I last saw the deceased alive on* Aug 11 1949 *and that death occurred at* 9¼ A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edward A. Flanigan Jr. M.D.
23B. ADDRESS: 3503 Fait AVE
23C. DATE SIGNED: 8-18-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 8/18/49
24C. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL
24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 18 1949
REGISTRAR'S SIGNATURE: [illegible] Registrar for Baltimore, Md.
25. FUNERAL DIRECTOR: WILLY & ZEILER
ADDRESS: BALTO. MD.

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Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77398

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77398

Registered No.

1. NAME OF DECEASED (Type or Print) ALBERT C. PATTERSON

2. DATE OF DEATH 8-18-49

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore 25 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1117 W 37th St. 13-6

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
M	W	M	July 6-1888	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber Retired	Self Employed	Maryland	U.S.A.

13. FATHER'S NAME Benjamin F. Patterson

14. MOTHER'S MAIDEN NAME Mary C. Stiffler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		—	Mrs. Anna B. Patterson	1117 W. 37th St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Myocardial infarction	5 hrs.
	DUE TO (B) Arteriosclerotic heart desease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 18, 1949, *to* Aug 18, 1949 *that I last saw the deceased alive on* Aug 18, 1949, *and that death occurred at* 2:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard A. Reed M. D.	Union Memorial Hospital	8/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 20-1949	Greenmount	York, Pennsylvania

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 18 1949	Huntington Williams, M.D.	Burgee Funeral Home	1631 Folk Road

VS 150

correct age is especially important. Physician: please write the cause of death clearly and legibly.

937

77399

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 77399

1. NAME OF DECEASED (Type or Print): Albert Hahn

2. DATE OF DEATH: August 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4135 Falls Road
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-7
D. STREET ADDRESS (If rural, give location): 4135 Falls Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Feb. 10, 1878
9. AGE (In years last birthday): 71
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Weaver (Retired)
10B. KIND OF BUSINESS OR INDUSTRY: Cotton Mill
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Hahn
14. MOTHER'S MAIDEN NAME: Mary Freeman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-10-1795
17. INFORMANT: Otto Hahn
ADDRESS: 4135 Falls Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis 3 yrs. — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
DUE TO Senility. Hernia feat

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 15th 1949 to Aug 16th, 1949 *that I last saw the deceased alive on* Aug 16th, 1949 *and that death occurred at* 9:30 P. m. *from the causes and on the date stated above.*

23A. SIGNATURE: B. G. Lucas M. D.
23B. ADDRESS: 36 1st Falls Rd.
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: August 19, 1949
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: AUG 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home
ADDRESS: 3631 Falls Road

VS 150

93E

CERTIFICATE CORRECTED 9-1-49 X ✓

G77400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4re

1 G77400

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)	HARRY R. (Sr.) BLANCK
2. DATE OF DEATH	August 17, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	Mercy Hospital
c. Length of stay in Baltimore (Yrs. Mos. Days)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Pennsylvania
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Philadelphia
D. STREET ADDRESS (If rural, give location)	2447 - 76th Avenue
5. SEX	Male
6. COLOR OR RACE	White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	Married
8. DATE OF BIRTH	Sept. 11, 1892
9. AGE (In years last birthday)	56
If under 1 year: Months / Days; If under 24 hours: Hours / Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Salesman
10B. KIND OF BUSINESS OR INDUSTRY	Plymouth-Miles Incl
11. BIRTHPLACE (State or foreign country)	~~Germany~~) Philadelphia, Pa.
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Henry Blanck
14. MOTHER'S MAIDEN NAME	Elizabeth Ruppert
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS	

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Artery Disease	
ANTECEDENT CAUSES	DUE TO (B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]
21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	W. J. McCafferty M.D.	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED	8-18-49	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	8-20-49	George Wash. Mem. Park	Phila.	Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 18 1949	Huddington Williams, MD	Ellsworth Armacost	94a 5118 Guzman Oak Ave.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G77401 — Registered No. 77401

E 974.0

N-991

1. NAME OF DECEASED (Type or Print): ANTON NEDUHAL

2. DATE OF DEATH: August 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore: 26 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 400 S. Pulaski Street 20-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Married	March 8, 1895	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber	Self.	Hungary	U.S.A.

13. FATHER'S NAME: Stephen Neduhal

14. MOTHER'S MAIDEN NAME: Suzanne Bon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	None	None	Elizabeth Neduhal	400 S. Pulaski St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Asphyxiation	
	DUE TO Strangulation	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	Shed at rear of 400 S. Pulaski St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐	NOT WHILE AT WORK ☒	21F. HOW DID INJURY OCCUR?
August 17, 1949 ?p m.			Hanged self from rafter in shed

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
H. J. McClafferty M.D.		Aug. 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-20-49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 18 1949	Huntington Williams, M.D.	George J. Schwab	2101 Rhedlink Ave.

VS 151

164a

Please write the cause of death in plain English. Physician's correct age is especially important.

G77402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G77402

1. NAME OF DECEASED (Type or Print): WILLIAM, MILNE

2. DATE OF DEATH: 8/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSP.
C. Length of stay in Baltimore: Years 3 Mos. 4 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Rural - Sykesville
D. STREET ADDRESS (If rural, give location):

5. SEX: M
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: Aug. 8 1868
9. AGE (In years last birthday): 80 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINISTER (PRESBY)
10B. KIND OF BUSINESS OR INDUSTRY: CHURCH
11. BIRTHPLACE (State or foreign country): Glasgow Scotland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Keith Milne
14. MOTHER'S MAIDEN NAME: Janet Lorimer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Mrs Wm L. Milne ADDRESS: Sykesville Md

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ARTERIOSCLEROTIC H.D.
DUE TO
(B) BENIGN. PROSTATIC HYPERT.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
ATELECTASIS & PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 3 days

19A. DATE OF OPERATION: 7-26-49
19B. MAJOR FINDINGS OF OPERATION: BENIGN PROST. HYPERT. & CYSTITIS
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-15, 1949, *to* 8-18, 1949, *that I last saw the deceased alive on* 8-18, 1949, *and that death occurred at* 6:30 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Hubert K. Spurrier M. D.
23B. ADDRESS: Univ. Hospital
23C. DATE SIGNED: 8/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-21-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Paran
24D. LOCATION (City, town, or county) (State): N. Randallstown, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. H. Weer ADDRESS: Sykesville, Md.

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137a

G77403

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

453 Registered No. G77403

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE BENBOW

2. DATE OF DEATH Aug. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 759 Edgewood St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 759 Edgewood St. 16-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Jan. 27, 1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone cutter, retired
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) England
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Benbow

14. MOTHER'S MAIDEN NAME Elizabeth Hindmoor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS Mrs Mary Holdson, 759 Edgewood St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic gangrene DUE TO peripheral vascular disease PERIPHERAL
(B) DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/4, 19 49 *to* 8/17, 19 49, *that I last saw the deceased alive on* 8/17, 19 49, *and that death occurred at* 4 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE Benjamin Mellor M. D.
23B. ADDRESS 2020 W Ellerslie Ave
23C. DATE SIGNED 8/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/20/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION (City, town, or county) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS William Cook, Inc., 1217 St. Paul St.

VS 150

93D

G77404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

571.0 G77404

Registered No.

BIRTH NO. B. C. 49-18788

1. NAME OF DECEASED (Type or Print) PERRYETTA SHEILA BLAKE

2. DATE OF DEATH AUGUST 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL

C. Length of stay in Baltimore 1½ Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 232 N. CARLTON 18-0

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	NEGRO	SINGLE	JUNE 28, 1949		1	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	INFANT	MARYLAND	U. S. A.

13. FATHER'S NAME THOMAS JONES

14. MOTHER'S MAIDEN NAME MARTHA BLAKE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	—	MOTHER	SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DEHYDRATION & ACIDOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

DUE TO

(B) DIARRHEA

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 15, 1949 *to* Aug 15, 1949 *that I last saw the deceased alive on* Aug 15, 1949 *and that death occurred at* 1 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edmund B. Middleton, M. D.	UNIVERSITY HOSPITAL	AUG 15 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL	AUG 18 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 19 1949	[illegible]	Commissioner of Health	

VS 150

119a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G77405 15791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77405

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ular, Hargett -or- Eula Hargett

2. DATE OF DEATH July 29, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave
C. Length of stay in Baltimore 19 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) No Home 26-17

5. SEX Female
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 4-6-1896
9. AGE (In years last birthday) 53 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME David Connor
14. MOTHER'S MAIDEN NAME Laura Hines

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Records Balto City Hospitals ADDRESS 4940 Eastern Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Minimal Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-20-36, 19__, *to* 7-29, 1949, *that I last saw the deceased alive on* 7-29, 19 49 *and that death occurred at* 8 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE R. Rogers M. D.
23B. ADDRESS Baltimore City Hospitals
23C. DATE SIGNED Aug. 17-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State) AUG 18 1949

DATE RECEIVED BY LOCAL REGISTRAR AUG 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Commissioner of Health
ADDRESS

VS 150

13B

G77406 JL -130042

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77406

1. NAME OF DECEASED (Type or Print): Lee Hurt

2. DATE OF DEATH: 8-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 26 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 821 Bradley St. 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Negro	Single	Feb. 2, 1901	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rufus Hurt

14. MOTHER'S MAIDEN NAME: Mary Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: B. C. H. Records, ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Far advanced Tuberculosis of the Lungs

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 2, 1949 *to* Aug. 9, 1949 *that I last saw the deceased alive on* Aug. 9, 1949 *and that death occurred at* 2.50 AM. *from the causes and on the date stated above.*

23A. SIGNATURE: R. L. Cozler M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: August 17-1949

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL AUG 18 1949
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: AUG 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

13B

G77407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓

'76 G77407 Registered No.

BIRTH NO. B.C 49-17366

1. NAME OF DECEASED (Type or Print): Baby Girl McBrien

2. DATE OF DEATH: Aug., 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for Women of Maryland, Lafayette + John Sts. Baltimore, Md.
C. Length of stay in Baltimore: Yrs. — Mos. — Days: 3 hrs. 27 min.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 824 Jeffery Street 25-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	Aug. 16, 1949			3 / 27

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Maryland	U.S.A.

13. FATHER'S NAME: George Stanley McBrien

14. MOTHER'S MAIDEN NAME: Florence Elizabeth Daubert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		none

17. INFORMANT: Florence Elizabeth Daubert — ADDRESS:

MEDICAL CERTIFICATION

(Please write clearly. Physicians: please be especially careful to report correct age in the case of deaths of infants under one year.)

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 16, 2:30 p.m., 1949, *to* Aug. 16, 5:30 p.m., 1949, *that I last saw the deceased alive on* Aug 16, 1949, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Alma Jogelberg M. D.	Hosp. for Women of Maryland	8-17-'49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		JOHN HOPKINS MEDICAL SCHOOL	AUG 18 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 18 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

159

G77408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77408

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): MARY BERGER

2. DATE OF DEATH: 8-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3010 Chelsea Terrace
C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-09
D. STREET ADDRESS (If rural, give location): 3010 Chelsea Terrace

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow		75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Hyman
14. MOTHER'S MAIDEN NAME: Rose
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Bertha Abelson ADDRESS: 3010 Chelsea Ter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Arteriosclerotic C. V. Disease — 8 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 17, 1949, *to* Aug 18, 1949, *that I last saw the deceased alive on* Aug 18, 1949 *and that death occurred at* 9 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Manuel Levin M. D.	7818 Reisterstown Rd	Aug 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-19-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 19 1949	Huntington Williams, M.D.	Jack Levin Inc	2100 Eutaw Pl

VS 150

937

G77409 X ✓ 51 G77409

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Ira Andrews

2. DATE OF DEATH: August 18,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Baltimore, Maryland
c. Length of stay in Baltimore: Yrs. 9 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chincoteague
D. STREET ADDRESS (If rural, give location): 297 South Main Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Jan. 6, 1898	51				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lt. Commander	USCG	Virginia	USA

13. FATHER'S NAME: William Andrews

14. MOTHER'S MAIDEN NAME: Florence ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
Yes	WW I - WW II	--

17. INFORMANT: Records - US Marine Hospital, Balto., Md. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of stomach with metastasis 5/4/6 and local extension.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Duration unknown

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* August 9, 1949, *to* Aug. 18, 1949, *that I last saw the deceased alive on* Aug. 18, 1949, *and that death occurred at* 8:15 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John [illegible] Wilson, Medical Director M. D.	US Marine Hospital, Balto., Md	8-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Aug 22-1949	Arlington Natl Cem	Arlington Virginia

DATE RECEIVED BY LOCAL REGISTRAR: AUG 19 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Robt C & B. McWalter

ADDRESS: Robt. F. Stucker

VS 150

46B

Correct age is especially important. Physicians: please write clearly and legibly.

G77410 CERTIFICATE CORRECTED 8-29-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77410

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Bernard McIsaac

2. DATE OF DEATH August (17) 18th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 913 Oldham St. 26-07

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH 2/28/1905 | 9. AGE (In years last birthday) 44 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OILER.
10B. KIND OF BUSINESS OR INDUSTRY Gas + Elect. Co.

11. BIRTHPLACE (State or foreign country) CANADA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME UNKNOWN

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No —
16. SOCIAL SECURITY NO. ?

17. INFORMANT Eleanor McIsaac ADDRESS SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED August 17th 18th 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 8/22/49
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Willy & Zeiler ADDRESS Balto. Md.

VS 151

94a

Please write the cause of death clearly and legibly. Physicians: please write correct age in spaces where important.

G77411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81.0

G77411

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) HARRY A. PETITT

2. DATE OF DEATH 8/18/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2025 GOUGH ST.

c. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2025 GOUGH ST. 2 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	MARRIED	2/8/1913	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MACHINE HAND	GAS & ELEC. CO.	MARYLAND	U.S.A.

13. FATHER'S NAME NEUTAN PETITT

14. MOTHER'S MAIDEN NAME MARIE SINIX

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			BARBARA PETITT	SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertrophic Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 8 mo.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-1-49, 19__, *to* 8/18/49, 19__, *that I last saw the deceased alive on* 8/17/49, 19__, *and that death occurred at* 1:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. H. Herrmann M.D.	1710 E 33rd St	8/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8/20/49	BALTIMORE MEM.	BALTO. CO.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 19 1949	Huntington Williams, M.D.	KELLY & ZEILER	BALTO. MD.

VS 150

1248

Note the Causes of death clearly and legibly. Correct age is especially important. Physicians: please write in ink.

G77412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G77412

1. NAME OF DECEASED (Type or Print): JESSE SPELLMAN

2. DATE OF DEATH: Aug. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 Warrington Road (WARRINGTON)

C. Length of stay in Baltimore: 30 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 33 Warrington Road 27-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Separated	/1908	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
GARDNER	PRIVATE FAMILY	McComas County, N.C.	U.S.A.

13. FATHER'S NAME: Edmond Spellman

14. MOTHER'S MAIDEN NAME: Mary Spellman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No		Wm Johnson-408 Penna Ave-Towson, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 day

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1945, *to* Aug, 1949, *that I last saw the deceased alive on* Aug 16, 1949, *and that death occurred at* 10A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis J. Kroll M. D.	1501 Eutaw Pl	8/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
Burial	8/21/49		Hertford, N.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 19 1949	Huntington Williams, M.D.	Charles R. Law, 802 Madison Ave-1

VS 150

94a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

TIFICATE CORRECTED 8-22-49

G77413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77413

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mr. John (~~Tulloch~~) TULLOCH

2. DATE OF DEATH 8/18/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore 20 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balt. 12-02
D. STREET ADDRESS (If rural, give location) 2907 St. Paul Street, Balto. Md.

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH June 2, 1896

9. AGE (In years last birthday) 53 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hair-dresser

10B. KIND OF BUSINESS OR INDUSTRY Department Store

11. BIRTHPLACE (State or foreign country) Scotland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME John (~~Tulloch~~) TULLOCH

14. MOTHER'S MAIDEN NAME Margaret Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Lily Tulloch (Mrs. ~~Lily Tulloch~~) ADDRESS Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial infarct. — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO

(B) Acute coronary occlusion — 12 hours

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 17, 1949 *to* Aug. 18, 1949 *that I last saw the deceased alive on* Aug. 18, 1949 *and that death occurred at* 12:35 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE J. Frank Supplee M.D.

23B. ADDRESS Union Memorial Hosp

23C. DATE SIGNED 8/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation

24B. DATE 8/20/49

24C. NAME OF CEMETERY OR CREMATORY Greenmount Crematory

24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 19 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Wm. J. TICHNER & SONS INC. North & Pa. Balto. 17, Md.

VS 150

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

CERTIFICATE CORRECTED 8-26-49

G77414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77414

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANKLIN H. BOWERSOX (FRANK)

2. DATE OF DEATH August 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 208 22nd Street (E) 12-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
male	white	Divorced.	May 4, 1902	47				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman	Textile	Baltimore, Md.	USA

13. FATHER'S NAME: Charles E. Bowersox

14. MOTHER'S MAIDEN NAME: Elizabeth Shaffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	213-03-5769	Miss Grace Bowersox	3904 Groveland Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial degeneration
DUE TO
(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE H. J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED August 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/22/49	Lorraine Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 19 1949	Huntington Williams, MD	WM. J. TICKNER & SONS INC.	North & Pa. Baltimore 17

VS 151

93D

Please write the cause of death very carefully and legibly. Physicians: please write the cause of death very carefully and legibly. Physicians: please write the cause of death very carefully and legibly. Physicians:

G77415

FALK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77415

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Eda Mae Falk

2. DATE OF DEATH Aug 12-49

3. PLACE OF DEATH
A. Baltimore City Maryland Balto City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1 1918 Breitwert Ave.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
1918 Breitwert Ave
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTO 25-43
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	widowed	1-13-1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Balto Co Md	

13. FATHER'S NAME
William Lester

14. MOTHER'S MAIDEN NAME
Emma Scarboro

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Paul Falk	1918 Breitwert Ave 30

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Bronchial Asthma — ?

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Sept 13, 1941, *to* Aug 16, 1949, *that I last saw the deceased alive on* Aug 14, 1949, *and that death occurred at* 10:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Carl P Rostberg M. D.	1316 W Lombard St	Aug. 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 20-49	Fowlon P K	Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 19 1949	Huntington Williams, M.D.	Edward Foulson	2359 West Blvd

VS 150

93E

Correct age is especially important. Physicians: please write clearly and legibly

G77416 128783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77416

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frank Golembieski - Golebiwski

2. DATE OF DEATH: 8- 17- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 41 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN: Baltimore
D. STREET ADDRESS (If rural, give location): 426 S. Bond ST, Z 31 3-01

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 5- 1908
9. AGE (In years last birthday): 41 Yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHAUFFEUR
10B. KIND OF BUSINESS OR INDUSTRY: KIMBLE-TYLER Co. COOPERAGE

11. BIRTHPLACE (State or foreign country): N.J.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew Golembieski

14. MOTHER'S MAIDEN NAME: Tillie Wisiewski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-01-3156

17. INFORMANT: Records B.C.H. 4940 Eastern Ave. (ADDRESS)

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Far Advanced Pulmonary Tuberculosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [ ] NO [X]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5- 6- , 1949 *to* 8- 17- , 1949 *that I last saw the deceased alive on* 8- 17- , 1949 *and that death occurred at* 4.15 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 8- 17- 49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 8-20-49
24C. NAME OF CEMETERY OR CREMATORY: SACRED HEART CEM.
24D. LOCATION (City, town, or county) (State): 7401 GERMAN HILL RD.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles S. Zeiler
ADDRESS: 901 S. Conkling St.

VS 150

131B

G77417 BANK ✓ 1 G77417

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Benjamin Banks

2. DATE OF DEATH: 8/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 2411 Callow Ave 1.3.01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	July 4/ 1895	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman (TRAVELING)

10B. KIND OF BUSINESS OR INDUSTRY: CLOTHING MFG.

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Morris Bank

14. MOTHER'S MAIDEN NAME: Ida Sheffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W.W. 1

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Emma Bank ADDRESS: 2411 Callow Avwnue

MEDICAL CERTIFICATION

(Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

G77418
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77418

1. NAME OF DECEASED (Type or Print): Amos W. McMillan
2. DATE OF DEATH: 18 Aug. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital (DOA)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Havre De Grace -Harford Co.Md.
D. STREET ADDRESS (If rural, give location): Stokes Street, Harford Co.Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	?	About 56 Years		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker	Bakery	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: Amos B. Mc Millan
14. MOTHER'S MAIDEN NAME: Alice A. Parrish

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
Unknown	?	Mrs. Howard Mitchell-2038 Cliftwood Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		INTERVAL BETWEEN ONSET AND DEATH
	(A) Coronary Disease	
DUE TO		
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
Wm. H. Kammer, Jr. M.D.		18 Aug. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-22-49	Baltimore Cemetery	East North Avenue, Balto: Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
AUG 19 1949	Huntington Williams, M.D.	George J. Ruth, Inc.-1735 Harford Avenue

VS 51

Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

94a

G77419 Turner G77419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Arnold Turner

2. DATE OF DEATH 8-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
640 George St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 640 George St., 17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Male	C.	Widower	Feb. 28, 1877	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Gas and Elec. Co.	Baltimore, Md.	U. S. A.

13. FATHER'S NAME Willis Turner.

14. MOTHER'S MAIDEN NAME Liza Cottman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Belle Turner.	578 Wilson St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of Rectum	2 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-17-49	Carcinoma of Rectum	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-3, 1949 *to* 8-17, 1949 *that I last saw the deceased alive on* 8-17, 1949 *and that death occurred at* 2:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William J. Holloway M. D.	Redwood & Greene Sts	8-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	8-21-49	W. M. Cultarn Co.	Balto	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 19 1949	Huntington Williams, M.D.	Mrs. Katie R. Williams	342 N. Schroeder St.

461

Correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G77420 ✓ G77420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 231 Registered No.

1. NAME OF DECEASED (Type or Print) Katie Ford Robinson

2. DATE OF DEATH 8/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) President Hosp.
C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1405 Madison Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1405 Madison Ave. 14-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	colored		April 4, 1886	63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	U. S. A.

13. FATHER'S NAME Hezekiah Lightford.

14. MOTHER'S MAIDEN NAME Annie Sample

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Caleb Robinson. ADDRESS 1405 Madison Ave.

MEDICAL CERTIFICATION

Correct age is especially important. Physicians: please write plainly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: Undet.

DUE TO

ANTECEDENT CAUSES

(B) Hypertension (Essential) — Undet.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-8, 1949 *to* 8-17, 1949, *that I last saw the deceased alive on* 8-17, 1949, *and that death occurred at* 10:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lewis A. Logan M. D.	President Hosp.	8-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 20, 1949	Mt. Auburn	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 19 1949	Huntington Williams, M.D.	Mrs Katie R. Williams Schroeder	322 N

AUG 1949

83a

G77421

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 916.3 G77421

Registered No.

1. NAME OF DECEASED (Type or Print) ANDREW BELLAMY — N-948.2

2. DATE OF DEATH August 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore
D. STREET ADDRESS (If rural, give location) 1018 Bond Street 7-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	Married	April 21, 1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Burner.
10B. KIND OF BUSINESS OR INDUSTRY: Patapsco Scrap Co. SCRAP METAL
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Andrew Bellamy
14. MOTHER'S MAIDEN NAME: Mary ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Georgeanna Bellamy ADDRESS 1018 Bond ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Burns, Third Degree
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): factory
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Patapsco Scrap Co., Fairfield 25/6
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): August 17, 1949 2p m.
21E. INJURY OCCURRED: WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Clothes ignited by explosion (gas)

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED August 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE Aug 20 1949
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State): Rocky Mt. N.C.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Bott G. Elliott Jr
ADDRESS: 1129 N. Caroline St

181

VS 131

correct age is especially important. Typewriting: please write

G77422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4th ward

G77422 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas GUINN

2. DATE OF DEATH: August 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 627 N. Spring St. S-01

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 19. 1895
9. AGE (In years last birthday): 53
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Helper
10B. KIND OF BUSINESS OR INDUSTRY: Box Factory

11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Guinn
14. MOTHER'S MAIDEN NAME: Nukown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Sarah Guinn
ADDRESS: 339A Rush Ct. TurnerHomes

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: August 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. 20. 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 19 1949
REGISTRAR'S SIGNATURE: Turlington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: 1000 Brantly Ave

VS 151

93D

Correct age is especia important. Hygienic, please write

677423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

677423

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EMMA T. Lee

2. DATE OF DEATH 8/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 319 N. Hoffman St.

C. Length of stay in Baltimore — Yrs. 44 yr. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-04
D. STREET ADDRESS (If rural, give location) 319 N. Hoffman St

5. SEX Female | 6. COLOR or RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH 2/16/1880 | 9. AGE (In years last birthday) 69 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Vineland N.J. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown | 14. MOTHER'S MAIDEN NAME Harriett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No. (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Hattie Willis | ADDRESS 319 N. Hoffman St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerosis Cardiovascular Disease

DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Thrombophlebitis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquery *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE John R Davis M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED 8/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug. 22, 1949 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn | 24D. LOCATION (City, town, or county) Baltimore, Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR AUG 19 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Holland Funeral Home | ADDRESS 1631 Druid Hill Ave 93

VS 151

correct age is especia... important. Physicians: please write the...

G77424

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77424 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ernest C Brown

2. DATE OF DEATH 8/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1606 Pennsylvania ave -

C. Length of stay in Baltimore 58 Yrs. ~~Mos.~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 14-0
D. STREET ADDRESS (If rural, give location) 1606 Pennsylvania ave

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married -
8. DATE OF BIRTH Oct-12-1890
9. AGE (In years last birthday) 58 If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer
10B. KIND OF BUSINESS OR INDUSTRY Department Store
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Cornelius Brown
14. MOTHER'S MAIDEN NAME Margaret
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes
16. SOCIAL SECURITY NO. 219-01-6944
17. INFORMANT Mary E Brown ADDRESS 1606 Penna -

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	2 mos.
DUE TO (B)	Hypertension Nephritis	4 mos
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/16, 1949 *to* 8/16, 1949 *that I last saw the deceased alive on* 8/16, 1949 *and that death occurred at* 7 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE David Trawlen M. D.
23B. ADDRESS 1224 W. Lee St
23C. DATE SIGNED 8/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug. 20, 1949
24C. NAME OF CEMETERY OR CREMATORY Baltimore National
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 19 1949
REGISTRAR'S SIGNATURE Timothy for Williams, M.D.
25. FUNERAL DIRECTOR Holland Funeral Home ADDRESS 760 Druid Hill Ave.

VS 150

832

77425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49 77425

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Mr. Anthony Joseph Smetana Sr.

2. DATE OF DEATH August 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore 62yr. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3723 Fleetwood Avenue 27-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Oct. 8 1864	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Baker	Europe	U.S.A.

13. FATHER'S NAME Joseph Smetana

14. MOTHER'S MAIDEN NAME Rose ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	------	None

17. INFORMANT Frances T. Smetana ADDRESS 3723 Fleetwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Arteriosclerosis
Senescence

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/12/ , 1949 *to* 8/18/ , 1949, *that I last saw the deceased alive on* 8/18/ , 1949, *and that death occurred at* 3:25 PM, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thaddeus Siwinski M. D.	1400 N. Caroline Street	8/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 22 1949	Holy Redeemer	4430 Belair Road Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 19 1949

REGISTRAR'S SIGNATURE Baltimore, Md

25. FUNERAL DIRECTOR ADDRESS Duffel Bro. 7110 Belair Rd.

VS 150

Siwinski

109a

Correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G 77426 ✓ 420.1 G 77426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 77426

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice G. Fields (Zimmerman)

2. DATE OF DEATH: Aug. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
c. Length of stay in Baltimore: 68 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1102 E. 20th Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Married	July 11, 1881	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	--	Baltimore, Md.	

13. FATHER'S NAME: Benjamin F. Sheppard

14. MOTHER'S MAIDEN NAME: Sarah Alice Burton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	215-24-6019	Walter M. Fields	1102 E.20th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	30 min.
DUE TO (B)	Partial small bowel obstruction	3 days
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-17- , 1949, *to* 8-18- , 1949 *that I last saw the deceased alive on* 8-18- , 1949 *and that death occurred at* 4:45P m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph R. Dola M. D.	Bon Secours Hospital	8-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-22-49	Lorraine Park	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
8-19-49	Huntington Williams, M.D	G. Howard Strong	3207 W. North Ave.

VS 150

94a

G77427 X ✓ G77427 27

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frederick Eberhart — 2. DATE OF DEATH: Aug 17, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto Genl Hosp

c. Length of stay in Baltimore: 57 Yrs. ---- Mos. ---- Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE: Md. b. COUNTY: Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Franklintown

d. STREET ADDRESS (If rural, give location): 1538 Ingleside Ave.,

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	9/16/1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rough Grinder	Crown Cork &Seal	Woodlawn, Md.	

13. FATHER'S NAME: JohnEberhart

14. MOTHER'S MAIDEN NAME: Mary E. Schmidt.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	W.W.1	212-05-2187	Mrs.Marie Eberhart	1538 Ingleside A.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occluseon — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquery (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: William G Helfrich M.D. — 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ — 23C. DATE SIGNED: Aug 19 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/20/49	Loudon Park	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 19 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: G. Howard Strong — ADDRESS: 3207 W. North Ave.,

94a ✓

Please write the cause of death clearly and legibly. Correct age is especially important. Physician: please write

G77428 BALTIMORE CITY HEALTH DEPARTMENT G77428

BIRTH NO. **CERTIFICATE OF DEATH** 443 Registered No.

1. NAME OF DECEASED (Type or Print) Charles Jackson

2. DATE OF DEATH August 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmhurst Nursing Home 1708 Eutaw Place
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1708 Eutaw Place 14-OV

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) ?
8. DATE OF BIRTH Jan. 13, 1873
9. AGE (In years last birthday) 76
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk
10B. KIND OF BUSINESS OR INDUSTRY Hotel Milner
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Not Known
14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS Boyd M. Andrews 4903 Alson Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive C. V. D.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 1948 *to* Aug. 18, 1949 *that I last saw the deceased alive on* Aug 18, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE Hamond J. Hankins M. D.
23B. ADDRESS 233X Eutaw St
23C. DATE SIGNED Aug 19 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8-20-1949
24C. NAME OF CEMETERY OR CREMATORY Good Shepherd
24D. LOCATION (City, town, or county) (State) Rockland, Howard Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS G. Howard Strong 3207 W. North Ave.

Correct age is especially important. Physicians, please

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G77429 ✓ X ✓ G77429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES Guy BRYAN

2. DATE OF DEATH: AUGUST 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Essex
D. STREET ADDRESS (If rural, give location): 168 Riverside Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Male	White	MARRIED	[redacted] 10-4-06	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Serviceman	Oil Burners.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Napoleon B. Bryan
14. MOTHER'S MAIDEN NAME: Mary L. Vandenberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	None		Marguerite L. Reid	1938 McHenry St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Degeneration
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
W. J. McClafferty M.D.		8-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-22-49	Western Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 19 1949	Huntington Williams, M.D.	George L. Schwab	2101 Brookside Ave

VS 151

93D

V

Please write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

G77430 Medical Examiner's Case ✓ X Released to Hospital G77430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. B.C. 48-03422

1. NAME OF DECEASED (Type or Print) Edwin L. Dunst — 057-1

2. DATE OF DEATH August 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore 18 mo (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dundalk
D. STREET ADDRESS (If rural, give location) 7953 Trappe Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Child	2-18-48	1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME [illegible] Dunst
14. MOTHER'S MAIDEN NAME Lyra Edwards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS ✓

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Septicemia (? meningococcemia)	- 24 hrs.
ANTECEDENT CAUSES	DUE TO (B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES X NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 8-18, 1949, to 8-18, 1949 *that I last saw the deceased alive on* 8-18, 1949, *and that death occurred at* 9 20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Wm H. Zuelzer M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 8-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 20 AUG. 1949
24C. NAME OF CEMETERY OR CREMATORY OAKLAWN CEMETERY
24D. LOCATION (City, town, or county) (State) EASTERN AVE, BALTO(19) Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 20 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR WALTER BROOKS - BRADLEY
ADDRESS 700 WILLOW SPRING RD. DUNDALK

VS 150

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Correct age is especially important. Physician, please write the

G77431

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

63

G77431

Registered No.

1. NAME OF DECEASED (Type or Print) Henry L. D. Wilkinson

2. DATE OF DEATH Aug 18 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6015 Pinehurst Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 6015 Pinehurst Road
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 6015 Pinehurst Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Sept 1st 1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Linoleum Layer	RETAIL FURNITURE STORE	Balto. Md.	

13. FATHER'S NAME William Willkinson

14. MOTHER'S MAIDEN NAME Susana Last.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		John Wilkinson	6015 Pinehurst Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of lung. — INTERVAL BETWEEN ONSET AND DEATH: 4 6 mos.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 17 1949 *to* Aug 18, 1949 *that I last saw the deceased alive on* Aug 17, 1949 *and that death occurred at* 11 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James R. Karns M. D.	700 Cathedral St	Aug 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 22, 1949	Woodland Memorial Cem	Taylor Sta

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Deputy for Williams, M.D.	John C. Moan	3600 E Baltimore St

VS 150

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G77432

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

387

G77432

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Edwin M. Hess

2. DATE OF DEATH: 8/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Northwood apts

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): Northwood apts 27-9

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Aug 12th 1879	70	— / 5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Asst. Gral Freight Agt	N. Y. Central R.R.	Md	

13. FATHER'S NAME: John Hess

14. MOTHER'S MAIDEN NAME: Elizabeth S. Ball

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
		Adella S. Hess, Northwood apts.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mal nutrition — INTERVAL BETWEEN ONSET AND DEATH: about 6 mo. duration

DUE TO

(B) Glaucoma - both eyes - 1942. one eye removed. Cataract and glaucoma in other eye nervous breakdown

DUE TO

(C) cerebral hemorrhage - 1944

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1942	P Glaucoma - both eyes	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 8, 1949 *to* aug 17, 1949, *that I last saw the deceased alive on* aug 17, 1949 *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter D. Tibbitt M. D.	2220 Garrison Blvd	aug 19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/20/49	Lorraine	Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Hunter for Williams, M.D.	Wm Cook Inc	1217 St. Paul st.

VS 150

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G77433

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 p.o. 1

G77433 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Richard A. Miller, Jr.

2. DATE OF DEATH: Aug. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3920 Ednor Road
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 3920 Ednor Road 9-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Nov. 28, 1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Theatre	Baltimore, Md.	

13. FATHER'S NAME: Richard A. Miller

14. MOTHER'S MAIDEN NAME: Sarah L. Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Mrs. Elizabeth Miller	3920 Ednor Road

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Thrombosis	
	DUE TO (B)	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1939 19__, *to* 8-17, 1949 *that I last saw the deceased alive on* 8-17, 1949 *and that death occurred at* 9:01 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. L. Ewald Jr. M.D.	36 Park Court	8/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 20, 1949	Greenmount Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Huntington Williams, M.D.	Wm. J. Tickner & Sons, Inc.	North & Pa.

VS 150

94a

G77434 X ✓ 51 G77434

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Edward A. Shorb

2. DATE OF DEATH: 8/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jenkins Memorial Hospital
C. Length of stay in Baltimore: 1 yr (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): York
D. STREET ADDRESS (If rural, give location): 2606 E. King Street

5. SEX: M.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: November 24, 1872
9. AGE (In years last birthday): 76 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe Salesman
10B. KIND OF BUSINESS OR INDUSTRY: ?
11. BIRTHPLACE (State or foreign country): Adams County, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John B. Shorb
14. MOTHER'S MAIDEN NAME: Mary A. Little

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: ADDRESS

MEDICAL CERTIFICATION

(Please write clearly, use ink. Do not use ditto marks. If unknown, state so. Do not abbreviate. Do not enter terminal conditions such as cardiac arrest, respiratory arrest, shock or uremia. Enter only the diseases, injuries or complications that caused death. Do not enter mode of dying. Do not enter symptoms. Be sure to complete items 19 to 24.)

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of stomach
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1948 *to* August 18, 1949 *that I last saw the deceased alive on* August 15, 1949 *and that death occurred at* 12 1. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Hubert J. Lenckos M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 8/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/22/49
24C. NAME OF CEMETERY OR ~~CREMATORY~~: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. H. Myers and Son
ADDRESS: 805 N. Calvert St

VS 150

46B

G77435

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77435

Registered No.

1. NAME OF DECEASED (Type or Print) JESSIE Smith

2. DATE OF DEATH 8/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days: life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 630 W. Franklin St. 17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Col.	single	MAY 8, 1901	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE. PORTER	ODD JOBS NONE	NORTH CAROLINA	U.S.

13. FATHER'S NAME: JESSIE Smith

14. MOTHER'S MAIDEN NAME: Lucy Boyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Generalized carcinomatosis	
ANTECEDENT CAUSES	DUE TO (B) Carcinoma of stomach	1½ yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
MAY, 1948	Gastric carcinoma	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 25, 1949 *to* Aug 15, 1949, *that I last saw the deceased alive on* Aug 14, 1949, *and that death occurred at* 1 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. W. Trettin M. D.	Mercy Hospital	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	8/20/49	Sacred Heart	Gorsuch Mill Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Huntington Williams, M.D.	J. J. Fahey & Son	1316 Light St

VS 150

46B

Correct age is especially important. Physicians: please write clearly and legibly.

G77436

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77436

1. NAME OF DECEASED (Type or Print) Sadie Genovese

2. DATE OF DEATH Aug. 19, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland Baltimore Md.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2121 Orleans St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 6-03
d. STREET ADDRESS (If rural, give location) 2121 Orleans St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	widowed	Dec 25-1906	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Telling coats + Housemaid	Tailoring	Italy	

13. FATHER'S NAME Sam Glorioso

14. MOTHER'S MAIDEN NAME Sadie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Sam Glorioso	W. Stephens St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Gall-Bladder with metastases to liver — INTERVAL BETWEEN ONSET AND DEATH 5 months

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
April, 11, 1949	Carcinoma of Gall-Bladder	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 6, 1949 *to* Aug. 19, 1949, *that I last saw the deceased alive on* Aug. 18, 1949, *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. Simmiello M. D.	Medical Arts Bldg	Aug. 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 22-1949	Holy Redeemer Cemetery	Belair Rd Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Countersigned for Williams M.D.	Joseph Farace Inc.	2013 Guenmont Ave

VS 150

46 F

G77437

CERTIFICATE CORRECTED 8-30-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 G77437 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HENRY ~~[illegible]~~ LEINEMAN

2. DATE OF DEATH 8-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 14. 27-03
D. STREET ADDRESS (If rural, give location) 2806 SOUTHERN ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	3/8/81	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Captain ~~[illegible]~~ dept.

10B. KIND OF BUSINESS OR INDUSTRY BALTO. CITY POLICE DEPT

11. BIRTHPLACE (State or foreign country) Germany Baltimore

12. CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME Helmerick Leinimen

14. MOTHER'S MAIDEN NAME Reinelt Hahnsen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchopneumonia	15 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B) Arteriosclerosis - generalized	6 yrs
	DUE TO (C) Hypertensive CV Disease	old
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/13, 1949, *to* 8/18, 1949, *that I last saw the deceased alive on* 8/19, 1949, *and that death occurred at* 6:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Henry Chartier Gerbel M. D. | 23B. ADDRESS Union memorial Hospital | 23C. DATE SIGNED 8-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/22/49 | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn | 24D. LOCATION (City, town, or county) (State) Colgate Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 20 1949 | REGISTRAR'S SIGNATURE Huntington Williams M.D. | 25. FUNERAL DIRECTOR Ulbrich Funeral Home | ADDRESS 2915 Eastern Ave

VS 150

937

Direct age is especially important. Physicians: please write the cause of death clearly and legibly.

77438

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 77438

1. NAME OF DECEASED (Type or Print): Ernest L. Leslie

2. DATE OF DEATH: Aug 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2725 Riggs Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 2725 Riggs Ave. 16-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	Aug. 11, 1903	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Md. Trust Co.,	Maryland	

13. FATHER'S NAME: Raymond M. Leslie

14. MOTHER'S MAIDEN NAME: Ruby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Lillian Leslie	2725 Riggs Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute Coronary Thrombosis	20 minutes
DUE TO	(B) Chronic myocarditis	sev. month
DUE TO	(C)	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	none other	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	none	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-19-49, 19__, *to* 8-19-49, 19__, *that I last saw the deceased alive on* 8-18-49, 19__ *and that death occurred at* 1.30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ernest L. Leslie M. D.	422 Med. Arts Bldg.	8-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 22, 1949	Lorraine	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Municipal Registrar, Md.	Ullrich Funeral Home	2008 Orleans St.,

VS 150

93D

Please write clearly and correct age is especially important. Physicians: please write clearly and legibly.

77439

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-06836

56 V G77439
Registered No.

1. NAME OF DECEASED (Type or Print): HERMAN WINTER

2. DATE OF DEATH: 8-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL
C. Length of stay in Baltimore: 4 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1708 CARSWELL ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
M	W	—	MARCH 24, 1949	—	4	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	BALT, MD.	—

13. FATHER'S NAME: HERMAN WINTER

14. MOTHER'S MAIDEN NAME: ELEANOR WARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	—	

17. INFORMANT: ELEANOR WARD — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) POST-OPERATIVE SHOCK — INTERVAL BETWEEN ONSET AND DEATH: 6 HRS.
DUE TO
(B) CIRRHOSIS LIVER — 3-4 MOS.?
DUE TO
(C) ATRESIA BILIARY APPARATUS — 4 MOS.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-17-49	CIRRHOSIS LIVER	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-14 1949 *to* 8-19 1949, *that I last saw the deceased alive on* 8-19 1949, *and that death occurred at* 6:15 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James A. Roberts M. D.	Mercy Hospital	8-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-20-49	New Cathedral	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Huntington Williams M.D.	Elmer W Conkle	924 E. Eager City.

VS 150

161 C

Please type the cause of death clearly and legibly. Important: Physicians: please write carefully. Correct age is especially important.

G77440

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97 1.8 G77440

Registered No.

1. NAME OF DECEASED (Type or Print) MARGARET MUMMA

N-979.0

2. DATE OF DEATH August 17, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Church Home Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN Fork
D. STREET ADDRESS (If rural; give location)

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: July 15-1907
9. AGE (In years last birthday): 42
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.a

13. FATHER'S NAME: Augustus Ely

14. MOTHER'S MAIDEN NAME: Carrie Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Elmer L. Mumma — ADDRESS: Hyde Md.

MEDICAL CERTIFICATION

write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty Degeneration of Liver — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Phosphorus Poisoning

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): BROADWAY & FAIRMOUNT AVE CHURCH HOME HOSPITAL

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): August 9 1949 2 m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Ingestion of phosphorus

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

23A. SIGNATURE: H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: August 18, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 20-49
24C. NAME OF CEMETERY OR CREMATORY: Fork M. E. Conn
24D. LOCATION (City, town, or county) (State): Fork Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 20 1949
REGISTRAR'S SIGNATURE: Investigator Williams, M.D.
25. FUNERAL DIRECTOR: Clarence E. Arthur — ADDRESS: Fork Md

VS 151

1639

G77441

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

463

G77441 Registered No.

1. NAME OF DECEASED (Type or Print): HARRY MEINHART

2. DATE OF DEATH: AUGUST 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 936 S. Bouldin Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Single	Feb.22,1904	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur	J. McKenzie Co.	Baltimore	

13. FATHER'S NAME: Herman Meinhart

14. MOTHER'S MAIDEN NAME: Elizabeth Schattner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Charles Hartman ADDRESS: 936 S.Bouldin St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Femoral Thrombophlebitis, left

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [✓], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]	23C. DATE SIGNED
W. J. McClafferty M.D.		8-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/22/49	Schwartz's	O'Donnell St.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 20 1949	Huntington Williams, M.D.	Clarence F. Hoffmann 1639 Broadway.

VS 151

100 B

Please write the cause of death clearly and legibly. Physician: please write correct age is especially important.

G77442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 0

G77442

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Baby "Girl" Gensler

2. DATE OF DEATH AUG 19 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3918 Foster Ave 76-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White		8-18-49				15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME Warren Gensler

14. MOTHER'S MAIDEN NAME Ruth Bradley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Evisceration	12hrs
DUE TO (B)	Ruptured omphalocoele	12hrs.
DUE TO (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-18- 1949, *to* 8-19 1949, *that I last saw the deceased alive on* 8-19 1949, *and that death occurred at* 150 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm H. Zinkham, M. D.	JOHNS HOPKINS HOSPITAL	8/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/20/49	Oak Lawn	7225 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Winston Williams M.D.	Clarence F. Hoffmann	1639 Broadway.

VS 150

1579

G77443
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77443
Registered No.

1. NAME OF DECEASED (Type or Print) Anna R. Figiel
2. DATE OF DEATH Aug. 18-1949
3. PLACE OF DEATH: A. Baltimore City, Maryland 6700 Gary ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —
C. Length of stay in Baltimore Life Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 6700 Gary ave 26-06
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 21-1900
9. AGE (In years last birthday) 49 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Ignatius Novak.
14. MOTHER'S MAIDEN NAME Alberta Revartz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Mr John A. Figiel ADDRESS 6700 Gary ave

MEDICAL CERTIFICATION

Collect age is especially important. Physician: please write the cause of death clearly and legibly.

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH 6 Mos
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1 19 49, *to* aug 18, 19 49, *that I last saw the deceased alive on* aug 18, 19 49, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE E R Evans M. D.
23B. ADDRESS 1 Liberty Parkway
23C. DATE SIGNED 8-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE aug. 22-1949
24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus
24D. LOCATION (City, town, or county) (State) Dundalk ave

DATE RECEIVED BY LOCAL REGISTRAR AUG 20 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR John J. Duda ADDRESS 2829 Hudson st

VS 150

46B

G7744 — BALTIMORE CITY HEALTH DEPARTMENT — G77447

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): LEVI DIGGS (CORNISH)

2. DATE OF DEATH: 8/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: BALT.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 630 W. Saratoga St — 4-0 Y-

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	BLACK	DIVORCED	1/18/1892	57	6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Porter	Stationery Co.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Levi Cornish

14. MOTHER'S MAIDEN NAME: Mary Diggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	None	212-14-1161

17. INFORMANT: Margaret Jennings(D) — ADDRESS: 1136 N Carey St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic CVD. — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) acute urinary retention; renal acidosis, uremic state, shock. — 5 days

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8/14/49	urethro-rectal fistula	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/14, 1949 *to* 8/16, 1949, *that I last saw the deceased alive on* 8/16, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert K. Spurs M. D.	Univ. Hosp.	8/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/20/49	Arbutus Mem'l. Pk.	Balto. County, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Huntington Williams, M.D.	Charles G. Cooper	512 N. Carrollton Av.

VS 150

136B

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G77445
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77445

1. NAME OF DECEASED (Type or Print): Baby Girl Moore
2. DATE OF DEATH: 8-15-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland St. Agnes Hosp.
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1111 Wildwood Pky 16-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	S	8-16-49		0 / 2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Newborn		Balto. Md.	

13. FATHER'S NAME: James Albert
14. MOTHER'S MAIDEN NAME: Muriel Adela Dow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			mother	1111 Wildwood Parkway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) Bilateral Atelectasis — 2 days
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-16, 1949 *to* 8-18, 1949 *that I last saw the deceased alive on* 8/18, 1949, *and that death occurred at* 12:10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo A Harwell M. D.	St Agnes Hospital	8/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 19, 1949	London Park	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Registrar for Millard, Md.	Fred A. Dodd	1913 Baltimore St

VS 150

161a

Please write the cause of death clearly and legibly. Physicians: please write exact age is especially important.

G77446 T. Breynard Starlings

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

27-1 G77446

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) C. Breynard Starlings

2. DATE OF DEATH 8/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-04

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2257 W. Baltimore St

C. Length of stay in Baltimore 40 yrs (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 2257 W. Baltimore St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	3/18/1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist	Crown Cork & Seal	Calvert Co. Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Starlings	Laura Tucker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		212-09-8061	Mrs Marie Starlings	2257 W Baltimore St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute bronchitis & Anasarca — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

DUE TO

(B) Chronic Pulmonary Emphysema — 4 years

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 45 *to* 8/17 49 *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
W. Henry Eshmann M. D.	1711 W Saratoga	8/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/20/49	Loudon Park	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	[illegible] for Registrar	Fred R. A. Ude	1913 W. Baltimore St

VS 150

93a

Please write clearly and legibly. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G77447 ✓ G77447

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 19

Registered No.

1. NAME OF DECEASED (Type or Print): ROSALIA V. O'DEA

2. DATE OF DEATH: Aug. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3520 N. Milton St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashburton Nursing Home

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4706 Delaware Ave. 27-16

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	Jan. 23, 1863	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	-	Baltimore, Md.	U.S.A

13. FATHER'S NAME: Charles E. Hawkins

14. MOTHER'S MAIDEN NAME: Mary Nolan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Miss E'lla Beauchamp	4706 Delaware Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Epithelioma of Chest wall
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) none

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 yr

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
—	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* June 1, 1949 *to* Aug 19 1949 *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr A C Heaver M. D.	4901 Garrison Blvd	8/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, county) (State)
Removal	8/22/49	Mt. Olivet Cem.	Washington, D. C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 19..	Huntington Williams, M.D.	Wm J. Dickey & Sons	Balto Md (17)

VS 150

47D

Please write the cause of death clearly and legibly. Physician: please write correct age is especially important.

G77448 JAMISON X ✓ G77448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ellsworth G. Jamison

2. DATE OF DEATH 8/19/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore Gen'l Hosp.

C. Length of stay in Baltimore 73 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Halethorpe

D. STREET ADDRESS (If rural, give location) 1520 Arbutus Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widower	Feb. 6, 1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Postman

10B. KIND OF BUSINESS OR INDUSTRY U.S. Postoffice

11. BIRTHPLACE (State or foreign country) Balto, MD

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME W. S. Jamison

14. MOTHER'S MAIDEN NAME Rachel Reynolds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) None (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Mr. Wm. L. Jamison ADDRESS 1520 Arbutus Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cancer of Rectum	10 yrs
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 8/10/49 19B. MAJOR FINDINGS OF OPERATION Probable Rectum

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/3/49 19 *to* 8/19 19 49 *that I last saw the deceased alive on* Aug 18, 19 49 *and that death occurred at* 5 20 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE Marion C. Bradley M.D. 23B. ADDRESS 109 W. Ostend St. 23C. DATE SIGNED Aug 19/1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation 24B. DATE 8/22/49 24C. NAME OF CEMETERY OR CREMATORY Greenmount Crematory 24D. LOCATION (City, town, or county) Baltimore Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR AUG 20 1949 REGISTRAR'S SIGNATURE [illegible] 25. FUNERAL DIRECTOR Wm. J. TICKNER & SONS INC. ADDRESS North & Pa. Balto. 17, Md.

VS 150

469

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

677449

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

677449 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elsie Schmauch — M

2. DATE OF DEATH 8/19/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 217 Oakley Village

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	July 29, 1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY -
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Calvin Lachman
14. MOTHER'S MAIDEN NAME Emma Fritzinger
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mr. Adam J. Schmauch ADDRESS 217 Oaklee Village

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 8/12/49 to 8/19/49
DUE TO
(B) Hypertension Cardio-vascular disease
DUE TO
(C)

ANTECEDENT CAUSES
II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/17, 1949, *to* 8/19, 1949, *that I last saw the deceased alive on* 8/18, 1949, *and that death occurred at* 7:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE William A. Anderson M. D. — 23B. ADDRESS 217 Cutting Avenue — 23C. DATE SIGNED 8/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE 8/22/49 — 24C. NAME OF CEMETERY OR CREMATORY Lorraine Cem — 24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 20 1949 — REGISTRAR'S SIGNATURE Elsie [illegible] Williams, M.D. — 25. FUNERAL DIRECTOR WM. J. TICHNER & SONS INC. — ADDRESS North & Ea. Balto. 17, Md.

VS 150

93D

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G77450

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77450 Registered No.

1. NAME OF DECEASED (Type or Print): Alfred Gilbert Ogle

2. DATE OF DEATH: August 19 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 519 Chestnut Hill Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

c. Length of stay in Baltimore: 10 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 9-12
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): ~~Ave~~ 519 Chestnut Hill Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	~~Widower~~ Divorced	Sept. 14 1881	67	11			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	State- Administrative	Baltimore, Md	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert Ogle	Sarah V. Metz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
None	217-16-5972	Mrs. Wallace Busick	519 Chestnut Hill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 5 days.

DUE TO

(B) Peripheral Vascular Disease — 5 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Arterio sclerosis — 3

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertension — 2

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 1, 1949 *to* August 19, 1949, *that I last saw the deceased alive on* Aug. 18, 1949, *and that death occurred at* 6:45 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James J. Baggett M. D.	3512 Greenmount Ave.	Aug. 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/22/49	Loudon Pk. Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	[illegible] Williams, M.D.	WM. J. TICKNER & SONS INC.	North & Fa. Ave Balto. 17, Md.

VS 150

8312

G77451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77451

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EMIL LITZAU

2. DATE OF DEATH: 8-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: 65 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Quarterfield Rd. Severn Md

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	Widowed	6-18-1875	74 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed	FARMER	Germany	U.S.A

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs John BLUNT	Balto Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congestive Cardiac Failure
DUE TO
(B) Arteriosclerotic Heart Disease.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/15 1949, to 8/19, 1949 *that I last saw the deceased alive on* 8/19, 1949, *and that death occurred at* 4.45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. K. Kaan M. D.	1400 N. Caroline St.	8/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	8/22/49	Friendships	Harmons Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Trustee for Williams, M.D.	Mildred I. Blight	6009 Harford Rd

VS 150

(14)

937

Exact age is especially important. Physicians: please write this

7452

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17 5

G77452 Registered No.

1. NAME OF DECEASED (Type or Print) MARTHA BELLE MARLEY

2. DATE OF DEATH Aug 18 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5606 Midwood Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN Balto (If outside corporate limits, write RURAL and give township) 77-48
D. STREET ADDRESS (If rural, give location) 5606 Midwood Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married	Sept 22 1891	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Practical Nurse	Hospital	Md.	

13. FATHER'S NAME Martin Jr. Arthur.

14. MOTHER'S MAIDEN NAME Atha Curry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	218-07-8501	Wm J. Marley	5606 Midwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of ovary
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 15 1949 to Aug 18, 1949 *that I last saw the deceased alive on* Aug 16 1949 *and that death occurred at* 3.10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edward H. Glassman M. D.	4037 Falls Rd	8/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 22 1949	Parkwood	Parkville

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Huntington Williams M.D.	Paul E. Shenouda Jr.	3615 Clarinda Ave

VS 150

49a

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

77453

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

330

Registered No. 77453

1. NAME OF DECEASED (Type or Print) Sarah Elizabeth Brown

2. DATE OF DEATH 8-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1411 - McCulloh 14-0r

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Widowed	12/26/1866	82 83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed		Florence, S.C.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
March Stevenson	Katherine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Morris Brown - 1401 McCulloh St

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Subarachnoid Hemorrhage	
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-17 1949 *to* 8-17 1949 *that I last saw the deceased alive on* 8-17 1949 *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. G. Bradyh M. D.	Provident Hospital	8-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/20/49	Mt Calvary	H.H. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 20 1949	Huntington Williams, M.D.	H. Halstead - 918 Druid Hill Ave.

VS 150

83a

Write the cause of death clearly and legibly. Correct age is especially important. Physicians: please write this

G77454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47

Registered No. G77454

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN SAMUEL COOK

2. DATE OF DEATH Aug 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 524 N. Stricker Street

c. Length of stay in Baltimore 45 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 524 N. Stricker Street 19-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	3/28/1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Longshoreman	MARITIME	Nottoway, Va.	U.S.A.

13. FATHER'S NAME: Emanuel Cook

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Laura P. Cook	524 N. Sticker Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular Renal Disease

DUE TO

(B) Congestive Failure.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 months

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

*21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 15, 1949, *to* Aug 18, 1949, *that I last saw the deceased alive on* Aug 18, 1949 *and that death occurred at* 5:50 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ralph W. Nellhaft M.D.	422 N. Johnson	8/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/22/49	Arbutus Memorial Park	Arbutus, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Huntington Williams, M.D.	A. HALSTEAD	918 Druid Hill Avenue

VS 150

Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

131a

G77455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77455 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sadie Talbot

2. DATE OF DEATH August 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1831 W. Lexington St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1831 W.LExington St. 20-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Single	2/10/1866	83	6	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	Self	Balto., Md.	U. S. A.

13. FATHER'S NAME Benjamin Talbott

14. MOTHER'S MAIDEN NAME Sarah V. Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	————	———

17. INFORMANT — ADDRESS: Minnie A. A. Smith 3503 Woodland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio vascular

DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Fracture ribs 7,8,9+10 on right.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS ~~ACCIDENTAL~~ OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
☑	Street	Baltimore & Fulton 20-1

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 12, 1949 ? m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
H. J. McCafferty M.D.		August 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/22	Druid Ridge	Catonsville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Interim for Williams, M.D.	Tilghman Co. Inc.	1217 St. Paul St.

VS 151

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

Inc 937

Shumate ✓

G77456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47

G77456

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Carrie Shumate

2. DATE OF DEATH 8-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp.

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 4-0 ✓
D. STREET ADDRESS (If rural, give location) 638 W. Saratoga St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	Separated	7-15-1902	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Greenville S.C.	U.S.

13. FATHER'S NAME Arthur Arnold

14. MOTHER'S MAIDEN NAME Lila ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Joe Lollis. ADDRESS 638 W Saratoga St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular Renal Disease

DUE TO (B) Encephalopathy of Uremia

DUE TO (C) Bronchopneumonia, Left Upper Lobe.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-17 1949 *to* 8-18, 1949, *that I last saw the deceased alive on* 8-18, 1949 *and that death occurred at* 1 P.M. *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T. G. Swinker Jr. M. D.	Univ. Hosp.	8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Aug 20, 1949	Greenville	South Carolina

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 20 1949	Hunter for Williams, MD	Mrs Katie R Williams	322 N Schroeder St

VS 150

131a

Please write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G77457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 175

G77457

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mabel Cassandra GREY

2. DATE OF DEATH Aug 21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital

C. Length of stay in Baltimore 20 Years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3101 Botetourt Ave. 27-03

5. SEX F

6. COLOR OR RACE W

7. (SINGLE) MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH Jan 13-99

9. AGE (In years last birthday) 50 — If Under 1 Year: Months 7 Days 8 — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE

10B. KIND OF BUSINESS OR INDUSTRY Private Nursing

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Nicholas Smith

14. MOTHER'S MAIDEN NAME Rosie Gemma Watts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Martin Grant

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of ovary

DUE TO

(B) with metastasis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Aug 18, 1949 *to* Aug 21, 1949 *that I last saw the deceased alive on* Aug 21, 1949 *and that death occurred at* 1:15 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE A. Andrew Alucci M. D.

23B. ADDRESS St Joseph's Hosp

23C. DATE SIGNED Aug 21-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Aug 24-49

24C. NAME OF CEMETERY OR CREMATORY Rock Spring

24D. LOCATION (City, town, or county) (State) Forest Hill Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 21 1949

REGISTRAR'S SIGNATURE Assistant for Williams, M.D.

25. FUNERAL DIRECTOR Martin Grant ADDRESS 49a Jarrettsville Md

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77458 ✓ 161 G77458 57

BIRTH NO. G77458 Registered No.

1. NAME OF DECEASED (Type or Print) Samuel Aronoff

2. DATE OF DEATH August 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3701 Columbus DRive

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 8 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3701 Columbus Drive 15 11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Stand Mt Royal Hotel

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Hirsh Aronoff

14. MOTHER'S MAIDEN NAME Ida Lipkin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Milton Glickman ADDRESS 3701 Columbus Drive

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Stomach — 3 yrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 21, 1946, to Aug. 20, 1949, *that I last saw the deceased alive on* Aug. 20, 1949, *and that death occurred at* 9:30 Am., *from the causes and on the date stated above.*

23A. SIGNATURE A. A. Silver M. D. | 23B. ADDRESS Fayette Gardens apt. | 23C. DATE SIGNED 8/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug 21, 1949 | 24C. NAME OF CEMETERY OR CREMATORY Hebrew Herring Run Cem | 24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 21 1949 | REGISTRAR'S SIGNATURE Tuntington Williams, M.D. | 25. FUNERAL DIRECTOR Sol Levinson & Bros | ADDRESS 1126 W North Ave

AUG 22 1949 Vs 156

A. A. SILVER

47a

Please write the cause of death and age in especial. Physician: please write the correct age in especial. Important.

G77459 G77459

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): JOHN H. WATSON

2. DATE OF DEATH: Aug 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 541 Bloom St-
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 40 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 541 Bloom St- 14-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Negro	Married	May 22, 1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Building Construction	Va	

13. FATHER'S NAME: Thomas B. Watson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	LOST	Mrs. Blanch Watson	541 Bloom St-

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chr. Myocarditis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 15 *, 1949, to* Aug 18 *, 1949, that I last saw the deceased alive on* Aug 18 *, 1949, and that death occurred at* 7:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
McDonald Bando M. D.	2445 Druid Hill Ave	8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 22, 1949	Asburies	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 21 1949	Huntington Williams, M.D.	Geo. L. Helbert	1303 Pennsylvania Ave

VS 150

93D

Please write the cause of death in plain English. Physician please write clearly and correct age is especially important.

G77460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77460

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MOLLIE GONCHARSKY

2. DATE OF DEATH: 8-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL ? BALTIMORE
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-or
D. STREET ADDRESS (If rural, give location): 2233 Brookfield Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	MARRIED		75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Louis Miller
14. MOTHER'S MAIDEN NAME: Rosa
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Abraham Goncharsky ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Extensive Pulmonary infiltration with metastasis	
DUE TO	(B) Papillary Serous Cystadenocarcinoma of ovaries	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Sept. 3 1947	Papillary serous cystadeno carcinoma of ovaries with metastasis	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-18, 1949 *to* 8-20, 1949, *that I last saw the deceased alive on* 8-20, 1949, *and that death occurred at* 5^40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
I Arnold H. Michael M. D.	SINAI HOSPITAL ? BALTIMORE	8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-21-49	Mishkan Israel	Dato Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 21 1949	[illegible]	Jack Lewis Inc	2100 Eutaw Pl

VS 150

49a

Please write the cause of death clearly and legibly. Physician: please write the exact age is especially important.

CERTIFICATE CORRECTED 2-2-61 G77461

G77461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Daniel Levin

2. DATE OF DEATH: Aug. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Marine Hospital Baltimore 11, Md.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2044 E. Fairmount Avenue 6-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Feb. 8, 1917	32		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Draftsman	?	Maryland	USA

13. FATHER'S NAME: Israel Levin

14. MOTHER'S MAIDEN NAME: ~~Naomi Levin~~ Anna Reece

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
Yes	WW II	

17. INFORMANT: Records - US Marine Hospital, Balto., Md. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Malignant melanoma left arm, with ~~pulm~~ extensive metastases to liver.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: July 1946

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Aug. 8, 1949, *to* Aug. 18, 1949, *that I last saw the deceased alive on* Aug. 18, 1949, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Medical Director M. D.	US Marine Hospital, Balto., Md.	8-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-21-49	Hebrew Mt Carmel	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 21 1949	Washington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

53

Please write the cause of death clearly and legibly. Physician: please write exact age if especially important.

G77462 ✓ 4 2 1 G77462

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): NOLIA LEAVERTON

2. DATE OF DEATH: Aug. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1425 W. Lexington St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1425 W. Lexington St. 19-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widowed	July 25, 1863	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home	Domestic	Harford Co. Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Jones	Harriett Hebron

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	4	None	Mrs. William Leaverton	752 Linyard St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO
(B) Arteriosclerotic CVD — 10 yrs
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1949 *to* Aug, 1949, *that I last saw the deceased alive on* Aug 19, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	1945 W. Baltimore St.	8/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/22/49	Loudon Park Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 24 1949	Hunter Williams, M.D.	WM. J. TICKNER & SONS INC	North & Pa. Balto. 17, Md.

VS 150 49 8

93D

Please write the cause of death clearly and legibly. Correct age is especially important. Physicians please write this.

BIRTH NO. 677463

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1 677463

1. NAME OF DECEASED (Type or Print): Cora Belle Shellkopf

2. DATE OF DEATH: Aug. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3026 Belmont Ave.
C. Length of stay in Baltimore: 6 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3026 Belmont Ave. 16 07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Apr. 7, 1867	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Oil City, Pa.	

13. FATHER'S NAME: Robert Wray

14. MOTHER'S MAIDEN NAME: Matilda Gibbons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		None	Mr. E. E. Shellkopf	3026 Belmont Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio-Vascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B)
DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 1, 1949 *to* Aug 20, 1949, *that I last saw the deceased alive on* Aug 20 1949, *and that death occurred at* 7:1 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert Scaquetti, M. D.	1724 W Lombard St	Aug 20 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Aug. 21, 1949	Allegheny Cemetery	Pittsburgh, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 21 1949	Entry for Williams, M.A. D.	Wm. J. Tickner & Sons, Inc.	North & Pa.

VS 150

937

Please write the cause of death clearly and legibly. Physician: please write. It is especially important. Physician: please write. Correct age is especially important.

G77464 | BALTIMORE CITY HEALTH DEPARTMENT | G77464

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edna May Mick

2. DATE OF DEATH: Aug 18-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2411 Hamilton Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-06
D. STREET ADDRESS (If rural, give location): 2411 Hamilton Avenue

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Nov. 8-1901
9. AGE (In years last birthday) / If under 1 year: Months / Days / If under 24 hours: Hours / Min.: 48

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Dickeyville, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Higgs
14. MOTHER'S MAIDEN NAME: Drusilla Freeze

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Frank J. Mick ADDRESS: 2411 Hamilton

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Circulatory failure	8 hrs.
DUE TO (B)	Mal nutrition	8 Months.
DUE TO (C)	Carcinoma of tongue---- and Carcinoma of Ovary----	11 mnth. 3½ yrs.
	Urinary fistula & Fecal fistula	3 yrs.

19A. DATE OF OPERATION: 2 Oct 48
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of tongue, epiglottis
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October, 1948, to Aug 17, 1949, *that I last saw the deceased alive on* Aug 17, 1949, *and that death occurred at* 12 noon, *from the causes and on the date stated above.*

23A. SIGNATURE: Robert J Berry M. D.
23B. ADDRESS: 24 Med. Arts Bldg.
23C. DATE SIGNED: 8/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-22-49
24C. NAME OF CEMETERY OR CREMATORY: Meadowridge
24D. LOCATION (City, town, or county) (State): Elkridge, Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck ADDRESS: 5305 Harford Rd.

VS 150

48a

Please write in ink. Physician: please write the cause of death clearly and correct age is especially important.

G77465 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77465 — Registered No.

1. NAME OF DECEASED (Type or Print): PHILIP J. HOCH

2. DATE OF DEATH: Aug. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2117 Dennison Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6604 Harford Road

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: May 26, 1870
9. AGE (In years last birthday): 79
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Co Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Alphonse Hoch
14. MOTHER'S MAIDEN NAME: Anna B. Dumbler
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Rosa E. Hoch, 6604 ADDRESS Harford Road.

MEDICAL CERTIFICATION

Cause the cause of death clearly and correct age is especially important. Physicians: please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 Hour

DUE TO

(B) Generalized Art & Cardiovascular Disease — Unknown

DUE TO

(C) Cerebral Arteriosclerosis & Senile Changes — Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* June, 1949 *to* Aug 19, 1949 *that I last saw the deceased alive on* Aug 19, 1949 *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis J. Tolan M. D.
23B. ADDRESS: 5804 Edmondson A.
23C. DATE SIGNED: 8/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-22-49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 21 1949
REGISTRAR'S SIGNATURE: [illegible] Baltimore, Md.
25. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, 5305 Harford Road.

VS 150

935

G77466

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 G77466

Registered No.

1. NAME OF DECEASED (Type or Print): Catherine (Kate) Dougherty

2. DATE OF DEATH: Aug 19-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2343 Eastern Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-03
D. STREET ADDRESS (If rural, give location): 2343 Eastern Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	widowed	Mar. 21-1864	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Balto Md.	

13. FATHER'S NAME: Nicholas Siemann

14. MOTHER'S MAIDEN NAME: Catherine Luebben

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Margaret Hess - ADDRESS: 3013 Pinewood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ARTERIOSCLEROSIS — INTERVAL BETWEEN ONSET AND DEATH: 10 YRS
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C) HYPERTENSIVE-CARDIO-VAS-RENAL DS — 10 YRS

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
ARTHRITIS — 8 YRS

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JUNE, 1949, *to* AUG 19, 1949, *that I last saw the deceased alive on* AUG 19, 1949, *and that death occurred at* 7.A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James F Kavanagh M D M. D.	3014 McElderry St	8-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/23/49	New Cathedral	Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 21 1949	Ruth for Williams	Leonard J Luck	5305 Harford Rd

VS 150

131a

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G77467.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77467. Registered No. 41-0

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ARISTA WATTS LACEY

2. DATE OF DEATH 8/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland Funeral
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN Baltimore 15-06 (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 3020 W. North Ave

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M

8. DATE OF BIRTH 6/28/07 | 9. AGE (In years last birthday) 42 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Arista W Lacey Sr
14. MOTHER'S MAIDEN NAME Emma E Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Collins O Lacy ADDRESS Eastport Md

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gastro-intestinal Hemorrhage
DUE TO
(B) Peptic ulcer
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/19 49 *to* 8/20 19 49, *that I last saw the deceased alive on* 8/20 19 49, *and that death occurred at* 7 45 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE Charles Blanke M. D. | 23B. ADDRESS Maryland Funeral | 23C. DATE SIGNED 8/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug 24/49 | 24C. NAME OF CEMETERY OR CREMATORY Cedar Bluff | 24D. LOCATION (City, town, or county) Annapolis (State) Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 24 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR B L Hopkins & Son ADDRESS Annapolis Md

117a

Please write the cause of death clearly and legibly. Physician, please write the correct age is especially important.

G77468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77468 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORE HENRY OTTERBEIN

2. DATE OF DEATH 9-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 18
D. STREET ADDRESS (If rural, give location) 2116 N CHARLES ST. 12-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W.	M	1/21/00	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ~~none~~ Clerk

10B. KIND OF BUSINESS OR INDUSTRY Produce Store

11. BIRTHPLACE (State or foreign country) MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME WILLIAM OTTERBEIN

14. MOTHER'S MAIDEN NAME AGNES Schwerman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes (If yes, give war or dates of service) W. W. #1

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Anna Brown ADDRESS 1815 N. Chas. st.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) aortic stenosis & mitral insufficiency, severe

DUE TO

(C) Rheumatic fever

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. acute gastritis, severe

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/20/, 1949, to 8/20/, 1949, *that I last saw the deceased alive on* 8-20, 1949, *and that death occurred at* 1:50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Charles H. Watt, Jr., M. D. — 23B. ADDRESS Union Memorial Hospital — 23C. DATE SIGNED 8/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE 8/23/49 — 24C. NAME OF CEMETERY OR CREMATORY U. S. National — 24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 22 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1217 St. Paul St.

VS 150

92 B

PLEASE WRITE PLAINLY with pencil or pen, and correct age is especially important. Physician: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77469 Registered No. G77469

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Anna J. Black

2. DATE OF DEATH 8/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2137 Callow Ave
C. Length of stay in Baltimore Yrs. Mos. Days Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2127 Callow Ave 13-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	July 17, 1888	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Ernest Stunk
14. MOTHER'S MAIDEN NAME Julia Doug

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT James C Black ADDRESS 5618 Loch Raven Blvd

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic Cardiovascular Disease	
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE John R Davis, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED 8/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/23
24C. NAME OF CEMETERY OR CREMATORY Druid Hill
24D. LOCATION (City, town, or county) (State) Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 22 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wilson & Son ADDRESS 1217 Hoal St

VS 151

93D

Please write plainly, using ink. Do not use pencil. Be sure the cause of death is entered clearly and legibly. Physician: please write the correct age is especially important.

G77470 ANNA LIPSCOMB G77470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Anna Lipscomb

2. DATE OF DEATH 8-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2306 McCulloh St
C. Length of stay in Baltimore 59 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 13-03
D. STREET ADDRESS (If rural, give location) 2306 McCulloh St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	C	W.	Feb 13 1890	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Balto. Md.	

13. FATHER'S NAME John Lipscomb

14. MOTHER'S MAIDEN NAME Eliza Hamm

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Evelyn J. Smith	2306 McCulloh

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arter. Insufficiency + contract. — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Hypertension + arteriosclerosis. — INTERVAL BETWEEN ONSET AND DEATH: .

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Cancer Cervix. — INTERVAL BETWEEN ONSET AND DEATH: ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-1- 1949 *to* 8-18- 1949, *that I last saw the deceased alive on* 8-18- 1949, *and that death occurred at* 7:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lucy E. Herman M. D.	2224 Madison Ave	8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 22/1949	Arbutus	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Washington Williams, MD	Geo. H. Pelton	1305 Maryland Ave

VS 150

48a

Please write the cause of death clearly and correct age is especially important. Physician, please write

G77471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77471

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jackson Harcum

2. DATE OF DEATH August 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2006 Brunt ST. 14-03

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: Mar 26 1913
9. AGE (In years last birthday.) 35 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Zack Harcum
14. MOTHER'S MAIDEN NAME Ada Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Ada Harcum ADDRESS 2006 Brunt St

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Degeneration
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. + Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED August 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 23, 1949
24C. NAME OF CEMETERY OR CREMATORY Arbutus
24D. LOCATION (City, town, or county) (State) md

DATE RECEIVED BY LOCAL REGISTRAR AUG 22 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR George S. Nelson ADDRESS 1305 Presstman St

VS 15T

931

G77472

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

57 0 5

G77472 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie Krider

2. DATE OF DEATH: 8/21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: 65 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 27-01
D. STREET ADDRESS (If rural, give location): 3806 Woodlea Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Mar. 6, 1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Kriele

14. MOTHER'S MAIDEN NAME: Annie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Albert Krider ADDRESS: 2007 Belair Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH: about 1 week

DUE TO (B) with hemorrhage due to unknown ET. 1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C) Cardiac failure — 2 weeks

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT. SUICIDE. HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-20, 1949 *to* 8-21, 1949, *that I last saw the deceased alive on* 8-21, 1949, *and that death occurred at* 8:34 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Margaret L Shennard M. D.
23B. ADDRESS: Mercy Hospital Balt.
23C. DATE SIGNED: 8-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 24/49
24C. NAME OF CEMETERY OR CREMATORY: Balto Cem
24D. LOCATION (City, town, or county) (State): Balto

DATE RECEIVED BY LOCAL REGISTRAR: AUG 22 1949
REGISTRAR'S SIGNATURE: Annaburgh Williams, M.D.
25. FUNERAL DIRECTOR: Ulman Funeral Hom ADDRESS: 2008 Orleans

VS 150

1228

Please write correct age if special. Physician: please write the cause of death clearly and legibly.

G77473

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77473 Registered No.

1. NAME OF DECEASED (Type or Print): Laura Hermana Anderson

2. DATE OF DEATH: 20 August 19[illegible]

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4703 Hampnet Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3708 Menlo Drive 27-21

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	DIVORCED	MAR. 5, 1888	61	5 / 15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ERNST RINGBORN
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. SAL VOGEL ADDRESS: 3708 MENLO DRIVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebrovascular accident (hemorrhage)	4 days
DUE TO (B)	Hypertension	Unknown
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 13 August 1949 to 20 August 1949, *that I last saw the deceased alive on* 19 August 1949 *and that death occurred at* 11 41 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Blume M. D.
23B. ADDRESS: 5602 Harford Rd
23C. DATE SIGNED: Aug 20/ 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: AUG. 23, 1949
24C. NAME OF CEMETERY OR CREMATORY: LOUDON PARK
24D. LOCATION (City, town, or county) (State): BALTO., MD.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: BALTO., MD.

83a

Please write the cause of death clearly and legibly. Physician please write correct age is especially important.

~~G77474~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~G77474~~ Registered No. G77474

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARD E. MILLER

2. DATE OF DEATH: Aug. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1208 Bloomingdale Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1208 Bloomingdale Rd. 16-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Jan. 11, 1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Construction	Marengo, Ind.	USA

13. FATHER'S NAME: Matthew Miller

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	137-05-3601	Mrs. Jessie Miller	1208 Bloomingdale Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease & Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: ? yrs. 2 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-19, 1949 *to* 8-19, 1949 *that I last saw the deceased alive on* 8-19, 1949, *and that death occurred at* 11:40 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Guy Ashman M. D.	1201 Taylor Ave St	8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/23/49	Loudon Park Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Huntington Williams, M.D.	Wm. J. McIMER & SONS INC	North & Pa. Balto. 17, Md.

VS 150

937

PLEASE WRITE PLAINLY, with unfading ink. Do not use pencil. Do not fold. Do not write above or below lines. Be sure to write the cause of death clearly and legibly. Physician: please write exact age if especially important.

G77475

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77475

PLEASE WRITE PLAINLY, with ink or indelible pencil. Physician please write the cause of death clearly and fully. Also please write if possible, correct age is especially important.

1. NAME OF DECEASED (Type or Print): IDA MAY REDMILES

2. DATE OF DEATH: Aug. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2141 Huntingdon Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 20 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2141 Huntingdon Ave. 12-07

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Mar. 4, 1879
9. AGE (In years last birthday): 70
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Savage, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Stephen Wheeler
14. MOTHER'S MAIDEN NAME: Corgette Sticker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Robert C. Redmiles
ADDRESS: 3021 Keswick Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Arteriosclerosis & Hypertension — DUE TO
(C) Paralytic Mullitus

INTERVAL BETWEEN ONSET AND DEATH
(A) 1 Day
(B) unknown
(C) unknown

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1939, *to* Aug 19, 1949 *that I last saw the deceased alive on* Aug 19, 1949, *and that death occurred at* A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles R. Goodbody M. D.
23B. ADDRESS: 2923 St. Paul St
23C. DATE SIGNED: 8/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/23/49
24C. NAME OF CEMETERY OR CREMATORY: St. Mary's Cem.
24D. LOCATION (City, town, or county) (State): Ramsden Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS INC.
ADDRESS: North & Pa. Aves Balto. 17, Md.

VS 150

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G77476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77476

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert Fields Sr.

2. DATE OF DEATH: Aug. 18-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2335 McElderry St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived if institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2335 McElderry St. 7-03

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar. 11-1878
9. AGE (In years last birthday): 71 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Fidelity Deposit Co
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Robert Fields
14. MOTHER'S MAIDEN NAME: Laura V. Hopper
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Dorothy Fields ADDRESS: 2335 McElderry St.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY with pen or pencil. Do not use ditto marks. Be sure the cause of death clearly and legibly. Physician's correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(B) Arteriosclerosis — ?
DUE TO
(C) Hypertension — ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1949 to Aug 18, 1949 that I last saw the deceased alive on Aug 17, 1949 and that death occurred at 1:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Louis J. Kilmes, M. D.
23B. ADDRESS: 2623 E. Monument St
23C. DATE SIGNED: 8/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. 22-49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Miller
ADDRESS: 2334 Jefferson St.

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G77477

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

44

G77477.

Registered No.

1. NAME OF DECEASED (Type or Print): Joseph T. Robinson

2. DATE OF DEATH: 8/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 126 S. Gilmor St
C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19 04
D. STREET ADDRESS (If rural, give location): 126 S. Gilmor St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 10, 1875
9. AGE (In years last birthday): 74
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James B. Robinson
14. MOTHER'S MAIDEN NAME: Ellen Bond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Margaret L. Robinson
ADDRESS: 126 S. Gilmor St

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, with ink or indelibly. Report one cause of death clearly and correct age is especially important. Physicians: please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage, Massive — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(B) Hypertension — years
DUE TO
(C) Arterioscleroti Cardio-vasc renal Dis — years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1940 to Aug 20, 1949 that I last saw the deceased alive on Aug 20 1949, and that death occurred at 7 45 p. m., from the causes and on the date stated above.

23A. SIGNATURE: (For M. Rachmiel, M.D.) Abram Goldman M.D.
23B. ADDRESS: 206 S. Gilmor St.
23C. DATE SIGNED: Aug. 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/23/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem
24D. LOCATION (City, town or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Pott & B. M. Walter
ADDRESS: Pratt & Stricker Sts

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G77478

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harold J. Popp

2. DATE OF DEATH: Aug 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Burg Mdg.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 14 Days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Michigan
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Saginaw
D. STREET ADDRESS (If rural, give location): 202 N. 5th St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 2-23-1893
9. AGE (In years last birthday): 56
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): District Manager
10B. KIND OF BUSINESS OR INDUSTRY: Pure Oil Co
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Popp
14. MOTHER'S MAIDEN NAME: Elizabeth Schaitberger
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): Yes W.W. I
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, with ink, and please write the cause of death clearly and correct age is especially important. Physician to sign and return promptly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial Hemorrhage.
DUE TO
(B) Prefrontal Lobotomy
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(over)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-8-, 1949 *to* 8-21-, 1949, *that I last saw the deceased alive on* 8-21 1949 *and that death occurred at* 7:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 8-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 22. 1949
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county). (State): Saginaw Michigan

DATE RECEIVED BY LOCAL REGISTRAR: AUG 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Rolf C. & B. M. Walters
ADDRESS: Court & Stricker

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G77479

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

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G77479

Registered No.

1. NAME OF DECEASED (Type or Print) Ida G. Taylor

2. DATE OF DEATH Aug. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 728 Dolphin St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 728 Dolphin St. 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Widow	Feb. 15, 1883	66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Virginia	U. S. A.

13. FATHER'S NAME James Ware

14. MOTHER'S MAIDEN NAME Mary Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS
Mrs Mable Chase — 728 Dolphin St.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician please write the correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Aug. 16, 49

DUE TO

(B) Hypertensive Cardio. Vasc. Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 16, 1949, *to* Aug. 19, 1949, *that I last saw the deceased alive on* Aug 19, 1949, *and that death occurred at* 6.30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald Bando M. D.	2445 Druid Hill Ave	Aug. 22, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-24-49	Mt. Auburn Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Huntington Williams, M.D.	Mrs. Frances A. Hensley	578 W. Biddle

VS 150

937

G77480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77480

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CARRIE OETTINGER

2. DATE OF DEATH 8-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Sinai Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

c. Length of stay in Baltimore 81 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Rivera apt 2F Balto
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md
D. STREET ADDRESS (If rural, give location) Linden ave 13-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Aug 21 1949	81	6 / 9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Keeping house	Balto Md	

13. FATHER'S NAME Mark Eisenbaum

14. MOTHER'S MAIDEN NAME Henrietta Kauffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
~	~	Mrs Leon Lauer Evergreen apt

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UREMIA

DUE TO

(B) Arteriosclerotic Hypertensive Cardiovascular Renal Disease

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in all blanks. Write the cause of death clearly and legibly. Physician's correct age is especially important. Please write the

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-13, 1949 *to* 8-21, 1949 *that I last saw the deceased alive on* 8-21, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leonard Katz M. D.	Sinai Hosp	8-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 23 1949	Beth Shalom	Odonnel Rd Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Huntington Williams, M.D.	David Sondheim & Son	1902 Eutaw Place

VS 150

1310

G77481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1 G77481 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM B. TANSILL, SR. 2. DATE OF DEATH 8-20-49

3. PLACE OF DEATH: A. Baltimore City, Maryland South Balto Gen Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.

c. Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 518 E Fort Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md

D. STREET ADDRESS (If rural, give location) 518 E Fort Ave 24-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	9/3/1893	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Oil Co	Va	USA

13. FATHER'S NAME William Tansill

14. MOTHER'S MAIDEN NAME Minna Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	216-03-7847	Mrs Wm B Tansill	518 E Fort

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill out completely all items, including cause of death clearly and legibly. Use only standard abbreviations. If cause is unknown, so state. Do not enter modes of dying, such as heart failure, asphyxia, anemia, or uremia, without assigning the disease or injury which caused them. Do not enter merely "cancer," "tuberculosis," etc., but specify the organ or part affected. Operations performed only to determine cause of death should not be reported. Do not report conditions which did not contribute to the death. Do not enter occupations such as laborer, clerk, etc. Correct age is especially important. Physicians are required by law to sign certificates of death promptly. Please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) CORONARY OCCLUSION

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. BRONCHOPNEUMONIA

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-8-, 19 49 *to* 8-20-, 19 49, *that I last saw the deceased alive on* 8-20-, 19 49, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Haig D. Yazujian M. D.	South Balto. Gen. Hosp.	8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	8/22/49	Cedar Hill	Ritchie Highway

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Huntington Williams, M.D.	J J Daley Home	1318 Light

VS 150

HAIG D. YAZUJIAN

94a

G77482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

20-1

G77482

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PAGONA MAGULAS

2. DATE OF DEATH 8/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2801 Huntingdon ave.

c. Length of stay in Baltimore 27 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 2801 Huntingdon ave. 12-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	widowed	Apr. 15, 1899	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home	---	Greece	U.S.A.

13. FATHER'S NAME Arestides Megaloeconomos

14. MOTHER'S MAIDEN NAME Sirmalenia Mavromati

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	none	Mr. Magulas	2801 Huntingdon ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physician must fill in the cause of death clearly and fully. Do not use abbreviations or symbols. Be correct and specific. Omit words not necessary to state the cause. If uncertain about any item, please write the word "unknown" rather than leave it blank. Be especially careful to fill in all items which are important. Physician's office address must be given.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestion Lungs R & L — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

DUE TO

(B) Lymphatic Metastasis Carcinomatosis. — .6 months

DUE TO

(C) Lymphosarcoma Lung. — 1 yr about

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 25, 1949 *to* Aug 18, 1949, *that I last saw the deceased alive on* Aug 18, 1949, *and that death occurred at* 10.30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James Graham Manton M. D.	516 Cathedral St	8-20-1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/22/49	Greek Orthodox Evangelismos	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Huntington Williams, M.D.	Geo. J. Agnew Funeral Home Inc	1187 N. Mt. Royal Ave.

VS 150

G77483

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77483

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply the cause of death clearly and correct age is especially important. Physician: please write the

MEDICAL CERTIFICATION

1. NAME OF DECEASED (Type or Print): William DeGele

2. DATE OF DEATH: Aug. 19/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3317 Devonshire Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 3317 Devonshire Rd.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location): 3317 Devonshire 27-20

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	June 7, 1863	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Balto. Md.	

13. FATHER'S NAME: ----DeGele

14. MOTHER'S MAIDEN NAME: ------unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
--	--	-----

17. INFORMANT: Mr. Geo. DeGele, 435 N. Bouldin St. (ADDRESS)

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C. V. disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/18 *19*49 *to* 8/19, 19 49, *that I last saw the deceased alive on* 8/18, 1949, *and that death occurred at* 8 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harold Wilson M. D.	5-724 Park Holtsville	8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 23/49	Schwartz's Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Hunting for Williams, M.D.	Philip Herwig Sons	2024 Orleans St.

VS 150

937

For approval of Medical Examiner

677484 — BALTIMORE CITY HEALTH DEPARTMENT — 903.0 — 677484

BIRTH NO. — CERTIFICATE OF DEATH — Registered No.

1. NAME OF DECEASED (Type or Print) John Strawbridge — 2. DATE OF DEATH Aug 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland St. Agnes Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. — B. COUNTY Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fallston
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	W		May 1, 1862	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SALESMAN (RET.)	PLUMBING FIXTURES	MD.	U.S.

13. FATHER'S NAME William

14. MOTHER'S MAIDEN NAME Mary McClung

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Intertrochanteric Fracture, Rt. Femur — 4 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

Per: C. J. Dubinski, M.D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Home	Fallston, Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Wed. Aug. 17, 1949 a.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Accidental - Not known (Slipped and fell to floor in bedroom)

22. *I hereby certify that I attended the deceased from* Aug 19, 1949 *to* Aug 21, 1949, *that I last saw the deceased alive on* Aug 21, 1949, *and that death occurred at* 7:10 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Stephen K. Padussis, M.D.	St. Agnes Hospital	8/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-24-49	Cokesbury	Abingdon, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Kenneth for Williams, M.D.	John O. Mitchell & Sons	1900 Eutaw Place

Mrs. Mitchell 186a

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Write the cause of death clearly and correct age is especially important. Physician: please write the

G77485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 90 3. 7 G77485

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Glendora Taylor — 2. DATE OF DEATH Aug. 22, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland Balt. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland Gen. Hosp.

C. Length of stay in Baltimore 4 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balt. Md. 12-06

D. STREET ADDRESS (If rural, give location) 2439 Maryland Ave #18.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	single	Oct. 10, 1857.	91		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Taylor

14. MOTHER'S MAIDEN NAME Isabella A. Sisco

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. ENTER ONLY ONE ITEM IN EACH SPACE. Do not abbreviate. Write the cause of death clearly and legibly. Do not enter modes of dying, such as heart failure, asphyxia, anemia, or uremia. Physician: please write the cause of death in terms of disease, injury, or complication which caused death, and please state the duration of each. If deceased was pregnant, or gave birth to a child within the year preceding death, please state the fact. If accident, suicide, or homicide, please state how injury occurred.

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A) Fracture of Left Hip

DUE TO

(B) Arteriosclerotic Heart Disease 3 months

DUE TO

(C)

CERTIFICATION APPROVED BY

Dr. W. G. Helprich

per Paul Boyd M.D.

CHIEF OR ASST. MEDICAL EXAMINER

INTERVAL BETWEEN ONSET AND DEATH: 3 months

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) ACCIDENT

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) HOME

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2439 MARYLAND AVENUE 12/6

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 5 25 49 m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Patient fell Slipped and fell to floor

22. *I hereby certify that I attended the deceased from* 5/26/, 1949 *to* 8/22/, 1949, *that I last saw the deceased alive on* 8/21/, 1949, *and that death occurred at* 2 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Paul G. Herold M. D. — 23B. ADDRESS Maryland Gen. Hosp. — 23C. DATE SIGNED Aug 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE Aug 24/49 — 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge — 24D. LOCATION (City, town, or county) (State) Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 22 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR John O. Mitchell Son — ADDRESS 1900 Eutaw Place

VS 150 certificate to be approved by medical examiner

186a

077486

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

077486 Registered No.

1. NAME OF DECEASED (Type or Print): Morris Stulman

2. DATE OF DEATH: 8-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5005 Litchfield Ave
C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-18
D. STREET ADDRESS (If rural, give location): 5005 Litchfield Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 72
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Oscar
14. MOTHER'S MAIDEN NAME: Fannie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Jessie Stulman ADDRESS 5005 Litchfield

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio. vascular Disease
DUE TO
(B) Coronary Occlusion
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH
(A) 5
(B) 30 minutes
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 19 49, to 8-21-, 1949, that I last saw the deceased alive on March, 1949, and that death occurred at 11:57 pm, from the causes and on the date stated above.

23A. SIGNATURE: A. A. Insoman M. D.
23B. ADDRESS: 1109 N. Calvert
23C. DATE SIGNED: F-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-22-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State): Hatto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc 2100
ADDRESS: Eastern Pl

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Be sure to write the cause of death clearly and legibly. Physician please write the correct age is especially important.

G77487

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77487

Registered No.

1. NAME OF DECEASED (Type or Print): REBECCA COPLAN

2. DATE OF DEATH: 8-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2424 Presbury St
C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-03
D. STREET ADDRESS (If rural, give location): 2424 Presbury St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 73 If under 1 year Months: Days If under 24 hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Solomon
14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Milton adler ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 8 mos.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Generalized Arteriosclerosis — Gross

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* 1944 *to* 9/21/49, *that I last saw the deceased alive on* 9/21/49, *and that death occurred at* 12 noon *from the causes and on the date stated above.*

23A. SIGNATURE: Clarence Cook Lee M. D.
23B. ADDRESS: 2320 Fulwood
23C. DATE SIGNED: 8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-22-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale.
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

46 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be correct age is especially important. Physician please write the cause of death clearly and legibly.

G77488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77488

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ABRAHAM WARTENSLEBEN

2. DATE OF DEATH 8/21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2207 Brookfield Ave

c. Length of stay in Baltimore 8 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-0

D. STREET ADDRESS (If rural, give location) 2207 Brookfield Ave

5. SEX Male

6. COLOR or RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH

9. AGE (In years last birthday) 65 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman

10B. KIND OF BUSINESS OR INDUSTRY Shirt

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob

14. MOTHER'S MAIDEN NAME Fannie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Ida Wartensleben ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Edema pulmonum

DUE TO Coronary Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* , 1945 *to* Aug 21, 1949 *that I last saw the deceased alive on* Aug. 21, 1949 *and that death occurred at* 6:35 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE Harold H. Bix M. D.

23B. ADDRESS 2516 Linden Ave

23C. DATE SIGNED Aug 21/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/22/49

24C. NAME OF CEMETERY OR CREMATORY Rosedale

24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 22 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Levine Inc

ADDRESS 2100 Eutaw Pl.

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physician please write the cause of death clearly and legibly. Be correct age is especially important.

G77489
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77489
Registered No.

1. NAME OF DECEASED (Type or Print): William D. Keating
2. DATE OF DEATH: 21 Aug. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital (DOA)
c. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 23 S. Arlington Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	8/11/1896	53				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer
10B. KIND OF BUSINESS OR INDUSTRY: Schaake Printing
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William D. Keating
14. MOTHER'S MAIDEN NAME: Annie C. Meders
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ✓
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Annie C. Clemens
ADDRESS: 23 S. Arlington Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Disease	
DUE TO		
(B)		
DUE TO		
(C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 21 Aug. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/24/49	New Cathedral	4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: AUG 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joshua J. Cowan & Son
ADDRESS: 95 Collins Ave

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be accurately supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G77490

G77490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77490

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Andrew Kopp.

2. DATE OF DEATH 8/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2112 Wilhelm St.

C. Length of stay in Baltimore Life Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-05
D. STREET ADDRESS (If rural, give location) 2112 Wilhelm St.

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH 1/14/1874
9. AGE (In years last birthday) 75
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brush maker
10B. KIND OF BUSINESS OR INDUSTRY Md Fiber Co.

11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Mamie Kopp ADDRESS 2112 Wilhelm St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

16. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilitation — INTERVAL BETWEEN ONSET AND DEATH: One day

DUE TO

(B) Cardio-Vascular disease — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 12th, 1949 *to* Aug 21, 1949 *that I last saw the deceased alive on* 21st, 1949, *and that death occurred at* 10A m. *from the causes and on the date stated above.*

23A. SIGNATURE Henry Glassman M. D.
23B. ADDRESS 753 W. Fayette St
23C. DATE SIGNED Aug 22 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/24/49
24C. NAME OF CEMETERY OR CREMATORY Western Cem.
24D. LOCATION (City, town, or county) (State) Longwood & Edmondson Ave

DATE RECEIVED BY LOCAL REGISTRAR AUG 22 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR John J. Lowandson
ADDRESS 901 Hollins St.

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Write the cause of death clearly and legibly. Physician please write the correct age is especially important.

G77491

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77491

1. NAME OF DECEASED (Type or Print): Edward Grimes McClure

2. DATE OF DEATH: August 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Standard Oil Dispensary ~~Bostaph Drug Co~~

C. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 39 N. Kossuth St. 20-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	MARRIED	OCT. 2, 1909	39				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
PIPE STILL OPERATOR	STANDARD OIL	MARYLAND	

13. FATHER'S NAME: late HEZEKIAH M'CLURE

14. MOTHER'S MAIDEN NAME: ANNIE P. JONES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			MRS EDWARD M'CLURE	39 N. KOSSUTH ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

(B)

ANTECEDENT CAUSES

II — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: W. J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: August 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	AUG. 22/1949	LOUDON PARK	3801 FRED'K RD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
VS AUG 22 1949	~~Livingston~~ Williams, M.D.	HARRY H. WITZKE	4101 EDMONDSON AVE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if possible. Be correct age is especially important. Physician: please write the cause of death clearly and legibly.

94a

G77492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77492

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Blanche May Haines

2. DATE OF DEATH: August 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4320 Falls Road

C. Length of stay in Baltimore: 62 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4320 Falls Road 27-15

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year Months Days	If under 24 hours Hours Min.
Female	White	Married	August 10, 1875	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	

13. FATHER'S NAME: Wesley H. Sykes

14. MOTHER'S MAIDEN NAME: Georgeann Hager

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	---	John S. Haines	4320 Falls Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency
DUE TO Chronic Glomerular Nephritis
(B) Acute Cystitis
DUE TO Senility
(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 3 yrs.
(B) 48 hours.
(C)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 11th, 1949, *to* Aug 19th, 1949, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 5:50 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
B. G. Leitch M. D.	361 N. Fauquier Ave. Baltimore	Aug 20th 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 22, 1949	Woodlawn	Baltimore Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the cause of death clearly and legibly. Physician please write correct age is especially important.

1219

G77493 U.T.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Hyo. 1

Registered No. G77493

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3615 Fourth Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst.. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 25-04
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 Fourth Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. SHEWBRIDGE

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Elmer E. Shewbridge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) II/26/1891

8. AGE: Years	Months	Days	If less than one day
57	8	22	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John C. Rice
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Wagner
15. Birthplace Md.

16 (a) Informant Family
(b) Address Same

17 (a) B (b) Date thereof 8/22/49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director James L. McCauley
(b) Address 130 East Fort Avenue

AUG 22 1949 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18 1949, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1948 to 8-16 1949, and that I last saw h.. alive on 8-16 1949.

Immediate cause of death Cardiac Failure — Duration
Due to Coronary Occlusion
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman Finberg M.D.
Address 940 Patapsco Ave 94a Date signed 8-18-49

G77494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77494

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CLARENCE H. KRAFT

2. DATE OF DEATH: August 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pasadena (DJM)
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	W	10/19/1888	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler Maker
10B. KIND OF BUSINESS OR INDUSTRY: Ship Repair Co
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Family - Same
ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. If any item is unknown, write "unknown." Physician: please write the cause of death clearly and legibly. Correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	8/23/49	Cedar Hill	Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 22 1949
REGISTRAR'S SIGNATURE: Farrington Williams, M.D.
25. FUNERAL DIRECTOR: James L. McCauley
ADDRESS: 130 E. Fort Ave.

VS 151

94a

G77495

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77495

1. NAME OF DECEASED (Type or Print): FLORENCE ABBOTT

2. DATE OF DEATH: 20 August 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 8 N. Bentalou St
C. Length of stay in Baltimore: 72 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 8 N. Bentalou 20-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed.	July 20 1877	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Home	Maryland	U. S.

13. FATHER'S NAME: ? Wheeler

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	Edward Lawrence	8 N. Bentalou

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

DUE TO

(B) Arterio-sclerotic heart disease — 7 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	none	none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	none.

22. *I hereby certify that I attended the deceased from* 20 Aug, 1949, *to* 20 Aug, 1949, *that I last saw the deceased alive on* 20 Aug, 1949, *and that death occurred at* 1130 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William Goodman, M. D.	1334 Eutaw Place Spring Road	20 Aug 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 23, 1949	Cedar Hill Cem.	A. A. Co, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Huntington Williams, M.D.	Flynn & Fleming	1426 Light St.

VS 150

Patient related by my colleague Dr. Benjamin Miller - Walbrook Ave hospital for heart trouble

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Enter the cause of death clearly and legibly. Correct age is especially important. Physician please write the

G77496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 7

G77496

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): ZNOVENA, Andrew

2. DATE OF DEATH: 8-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 718 S. LUZERNE AVENUE 1-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	11/30/10	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SHEET-METAL WORKER	SHIPBUILDING	MARYLAND	U.S.

13. FATHER'S NAME: JOSEPH ZNOVENA

14. MOTHER'S MAIDEN NAME: MARGARET WASIK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	—	

17. INFORMANT: MARIE ZNOVENA ADDRESS: 718 S. LUZERNE AVENUE

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anopia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) laryngeal spasm, edema

DUE TO

(C) Ludwig's Angina

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

anesthesia + operative intervention

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
8-21-49		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-1-49, 1949, *to* 8-21, 1949, *that I last saw the deceased alive on* 8-21, 1949, *and that death occurred at* 1:15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Daniel M Bisanar M. D.	University Hospital	8-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8/24/49	St. Stanislaus	BALTIMORE MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 22 1949	Hunter Washington, M.D.	M.F. SADOWSKI & SONS, 808 EASTERN AVE.

VS 150

1151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the cause of death clearly and legibly. Physician: please write correct age is especially important.

G77497.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3 3

G77497.

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN W. WIEGAND

2. DATE OF DEATH Aug 20. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4203 Springdale Av

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mrs. Lewis Nursing Home

C. Length of stay in Baltimore 75 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1314 S. Carey St. 21-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	Feb 10, 1874	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Painter	Standard Oil Co	Baltimore Md	

13. FATHER'S NAME Herman W. Wiegand

14. MOTHER'S MAIDEN NAME Ernestine Wieland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	213-10-7611	Myrtle E. Robinson	1256 Carroll St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral embolus — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) arteriosclerosis
DUE TO Cardiac insufficiency
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__ *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__. *and that death occurred at* 5-45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr Bernard Robinson M. D.	Marlboro Md	8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 23. 1949	Loudon Park	Balto - Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Huntington Williams M.D.	Jno. Wm. John H. Teufel Son	5311 Edmondson ave

VS 150

83B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly given. Be sure to write the cause of death clearly and legibly. Physician: please write the correct age is especially important.

G77498

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 v 1

G77498 Registered No.

1. NAME OF DECEASED (Type or Print): LAURA HUTCHINS

2. DATE OF DEATH: Aug. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Beechfield Nursing Home 6028 Old Harford Rd.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 142 W. Lanvale St.

11-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single		about 88 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Lewis Harman Hutchins

14. MOTHER'S MAIDEN NAME: Katherine Kennard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Mrs. Joseph I. Greene
ADDRESS: 612 Marlyn Apts. 612 Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

(B) Arteriosclerotic Cardio-Vascular Disease — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 15 August 1949 *to* 21 August 1949, *that I last saw the deceased alive on* 20 August 19 49, *and that death occurred at* 9:00 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jos. M. Greene M. D.
23B. ADDRESS: 2038 Harford Rd.
23C. DATE SIGNED: 22 Aug. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/23/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Physician please write the correct age is especially important. Please write the cause of death clearly and legibly.

G77499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77499

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RAYMOND H. BOZMAN

2. DATE OF DEATH: Aug. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2807 Southern Ave.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2807 Southern Ave. 27-02

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Feb. 11, 1888
9. AGE (In years last birthday): 61 yrs. If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): President
10B. KIND OF BUSINESS OR INDUSTRY: Retail Refrigeration
11. BIRTHPLACE (State or foreign country): Eden, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Bozman
14. MOTHER'S MAIDEN NAME: Caroline Pusey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Jessie A. Bozman — ADDRESS: 2807 Southern Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 mos

DUE TO

(B) Arterio-Sclerosis — 1 yr.

DUE TO

(C) Coronary Disease — 1 yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 12, 1949 *to* Aug 21, 1949, *that I last saw the deceased alive on* Aug 21, 19 49, *and that death occurred at* 2 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Edward H. Benson M. D.
23B. ADDRESS: 1 W. Overlea Ave.
23C. DATE SIGNED: 8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/25/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physician please write the cause of death clearly and legibly.

G77500

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77500

1. NAME OF DECEASED (Type or Print): Isabella Clendenin Prather

2. DATE OF DEATH: Aug 20-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — 3021 Baker St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 69 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 3021 Baker St Balto Md
D. STREET ADDRESS (If rural, give location): 3021 Baker St 16-07

5. SEX: F.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Apl-16-1880
9. AGE (In years last birthday): 69
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A?
13. FATHER'S NAME: Arthur A. Clendenin
14. MOTHER'S MAIDEN NAME: Emily Chipman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: W.Frank Prather
ADDRESS: 3021 Baker St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Angina Pectoris Acute — Interval between onset and death: 20 minutes

DUE TO

(B) Angina Pectoris, Subacute Recurrent — 10 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ____, 1949, to Aug 20, 1949, that I last saw the deceased alive on Aug 20, 1949, and that death occurred at 10 A.M., from the causes and on the date stated above.

23A. SIGNATURE: C.W. Hoffman, M. D. M. D.
23B. ADDRESS: 8 East Read Street
23C. DATE SIGNED: 8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug-23-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Bateman & Lore
ADDRESS: 2224 N.Charles St

VS 150

94B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, as correct age is especially important. Physician please write to the cause of death clearly and legibly.

G77501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

120-1

G77501 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANNIE THOMPSON

2. DATE OF DEATH 8/19/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CALVERT HALL COLLEGE Cathedral & Mulberry Sts

c. Length of stay in Baltimore 50yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md.

D. STREET ADDRESS (If rural, give location) 719 Dolphin St 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Widowed	5/15/1885	64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cook	Domsetic	Harford County, Md.	U.S.A.

13. FATHER'S NAME John Hall

14. MOTHER'S MAIDEN NAME Annie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	No	

17. INFORMANT Magdeline Trusty ADDRESS 1006 W Franklin St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
I (A)	Coronary Thrombosis	15 min.
DUE TO (B)	Arteriosclerotic Cardio-Vascular disease with Hypertension.	2 yrs.
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct. 24, 1947 *to* Aug. 19, 1949 *that I last saw the deceased alive on* Aug. 19, 1949 *and that death occurred at* 7:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	Medical Arts Bldg	Aug. 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/22/49	Mt. Auburn	Balto, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Huntington Williams, M.D.	Charles Horpel	512 Gonvelas Ave

VS 1-50

931

G77502

BIRTH NO. B.C.49-11633

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

527.1 G77502 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Hartley

2. DATE OF DEATH: 8-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. Gen. Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 3623 Elkader Road 9-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	S	June 9th 1949		2	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Norman S. Hartley
14. MOTHER'S MAIDEN NAME: Florence Helmley.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Norman S. Hartley ADDRESS 3623 Elkader Rd

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY with ink. Physician: please write the cause of death clearly and correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Obstructive emphysema
DUE TO cause undetermined
(B)
DUE TO
(C) Prematurity

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 wks

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-4- 1949, *to* 8-21 1949, *that I last saw the deceased alive on* 8-21 1949, *and that death occurred at* 8:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm D. Davis M. D.
23B. ADDRESS: West Baltimore Gen Hosp
23C. DATE SIGNED: 8-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 23rd 1949
24C. NAME OF CEMETERY OR CREMATORY: Moreland
24D. LOCATION (City, town, or county) (State): Taylor Ave

DATE RECEIVED BY LOCAL REGISTRAR: AUG 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leo D. Cook ADDRESS 1703 N. Patterson Park Ave

VS. 450

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G77503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77503

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Agnes L Smith

2. DATE OF DEATH Aug. 17-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2114 W Saratoga St

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2114 W. Saratoga St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	12/26/1865	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Hse.	at Home	Balto. Md	USA

13. FATHER'S NAME Henry Smith

14. MOTHER'S MAIDEN NAME Margaret Lillie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT Edna Heerd ADDRESS Same

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY. Physician: please write the cause of death clearly and accurately. Be especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

(B) Arteriosclerotic Cardio-Vascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Senility

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/12, 1949 *to* 8/17, 1949, *that I last saw the deceased alive on* 8/17, 1949, *and that death occurred at* 9:5 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Clive Laughlin M. D.	4508 Edmondson Village	8/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 22 49	Loudon Park	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Huntington Williams, M.D.	J. Elliott Hurst & Son	1300 Eutaw Pl. 17

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G77504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420 | G77504 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Libbie G. Smuck

2. DATE OF DEATH Aug. 19-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1548 Northgate Road
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City 27-09
D. STREET ADDRESS (If rural, give location) 1548 Northgate Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	10/31/1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Rt. Home	Baltimore-Md.	U.S.A.

13. FATHER'S NAME George Godfrey

14. MOTHER'S MAIDEN NAME Martha Holmes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.			Samuel N. Godfrey	Home

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2-3 minutes

DUE TO

(B) Hypertension C.V. Disease — ?

DUE TO

(C) Arteriosclerosis, generalized — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1949, *to* August 19, 1949, *that I last saw the deceased alive on* August 18, 1949, *and that death occurred at* 3 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sydney D. Godfrey, M. D.	Medical City Bldg	August 20 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 22/49	Mt. Olivet	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949	Huntington Williams, M.D.	C. B. Nippert & Son	937 1300 Eutaw Pl.

PLEASE WRITE PLAINLY. Physician: please write the cause of death clearly and accurately. Be especially important. Physician: please write the cause of death clearly and accurately.

G77505 X ✓ 53 G77505

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Harry Tenley

2. DATE OF DEATH: Aug. 22, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR ~~INSTITUTION~~ (If not in hospital or institution, give street address or location): St. Joseph
c. Length of stay in Baltimore: Yrs. ~~Mos.~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural (Bel Air)
d. STREET ADDRESS (If rural, give location): None

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	Married		52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	Individual	Maryland	US

13. FATHER'S NAME: Geo. D. Tenley

14. MOTHER'S MAIDEN NAME: Anna Tenley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mrs. Ellen Tenley	Bel Air, Md.

MEDICAL CERTIFICATION

Please write the cause of death clearly and legibly. Physician: please write in the space below the cause of death which is especially important. Please give exact age in years.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

(B) Carcinoma, sigmoid — unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 18, 1949 *to* Aug. 22, 1949, *that I last saw the deceased alive on* Aug. 22, 1949 *and that death occurred at* 5 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James D. d'Oare M. D.	1100 N. Caroline St.	Aug. 22, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 25/49	St Ignatius	Hickory Harford Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 22 1949 VS 150	Huntington Williams, M.D.	Joseph T. Forbes	Bel Air Md

46E

G77506

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77506
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RUSSELL HARRISON WAMBAUGH

2. DATE OF DEATH 8-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon. Secours Hospt.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE MARYLAND
B. COUNTY Montgomery
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) SILVER SPRINGS
D. STREET ADDRESS (If rural, give location) 305 Ellsworth Dr. W

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	8-4-89	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		PA	USA

13. FATHER'S NAME Clinton Wambaugh

14. MOTHER'S MAIDEN NAME Ella Mertz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Lt R Patterson	Glen Rock Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Testicle + Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Edema + Edema

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-19-49, 19__, *to* 8-23, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph R. Dolee M. D.	Bon Secours Hosp	23 Aug. 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
	Aug 25 1949	Reformed	Glen Rock, Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Huntington Williams, M.D.	H. C. Seifert	Glen Rock, Pa

VS 150

5/c

Please write the cause of death clearly and legibly. Physician: please write in full and especially important. Exact age is especially important.

G77507 ✓ G77507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 32 v. 1

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John B. Evans

2. DATE OF DEATH Aug 22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 526 Chapel Gate Lane (If not in hospital or institution, give street address or location)

B. FULL NAME OF HOSPITAL OR INSTITUTION Ventnor Lodge N. H.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1008 E. North Ave 9-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M.	W.	Single	Feb. 19/02	47	6	3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thomas R. Evans

14. MOTHER'S MAIDEN NAME Margaret Burns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 051-16-1133

17. INFORMANT Mrs Anna Humphrey ADDRESS 2714 Barenwood

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic alcoholism — ?

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) — ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Myocarditis

20. AUTOPSY? YES ☐ NO ☒

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 20, 1949, to August 22, 1949, *that I last saw the deceased alive on* August 21 1949, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Melvin N. Binder M. D.

23B. ADDRESS 2030 W. Fayette St

23C. DATE SIGNED 8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/24/49

24C. NAME OF CEMETERY OR CREMATORY [illegible] Cathedral

24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR AUG 23 1949

REGISTRAR'S SIGNATURE [illegible]

25. FUNERAL DIRECTOR Rita Wiedefeld

ADDRESS 900 E. Biddle St

937

VS 150

Write the cause of death clearly; please write correct age is especially important. Physician:

G77:08 ✓ G77:08

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH E97 20

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNA MAY PRESTON N-968

2. DATE OF DEATH: August 21, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1023 Bonaparte Avenue 9-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Sept 16 1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		York Pa	

13. FATHER'S NAME: John F Scheffer

14. MOTHER'S MAIDEN NAME: Sarah (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Samuel F Preston	1023 Bonaparte Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Asphyxiation due to illuminating gas	
ANTECEDENT CAUSES	DUE TO (B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	1027 Bonaparte Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 21, 1949 ?P.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Four burners on stove on but unlit

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl F Moyer M.D.		8-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buria	8/23/49	Lorraine Pk	Baltown Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Huntington Williams, M.D.	Wilmot & Dare	1219 E Fayette St

VS 151

163H

Please write the cause of death clearly and legibly. Physician: please write the exact age if especially important.

G77509 ✓ G77509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 972.8

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SILAS B. BISER N-968

2. DATE OF DEATH August 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2209 St. Paul Street 12-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	1-20-01	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Leivistown, Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Victor R. Biser
14. MOTHER'S MAIDEN NAME Alva Geesey ✓
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 212-03-9016
17. INFORMANT Mrs. Marion Green ADDRESS Rt. 86, Frederick, Md

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation due to illuminating gas
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2209 St. Paul Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 14, 1949 (?) ? m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Three burners on but unlit on stove

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE D. J. Tulinski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ✓
23C. DATE SIGNED 8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-23-49	Utica Cemetery	W. Lewistown, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 23 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR M. R. Etchison & Son, ADDRESS Frederick, Md.

VS 151

163H

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write correct age is especially important.

G77510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

584 G77510 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ruth Blackwell Lawrence

2. DATE OF DEATH Aug. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hosp.
C. Length of stay in Baltimore 5 4 yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-01
D. STREET ADDRESS (If rural, give location) 1033 N. Fanvale St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Married	Oct. 16, 1894	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Balto. Md.	U. S. A.

13. FATHER'S NAME William Blackwell

14. MOTHER'S MAIDEN NAME Laura Bishop

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Mr. C. Mansell Lawrence ADDRESS 1033 N. Fanvale St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Postoperative Shock — INTERVAL BETWEEN ONSET AND DEATH 8/19/49

DUE TO

(B) Acute Cholecystolitis

DUE TO

(C) Cholelithiasis & mitral gangrene

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8/19/49	Same as above	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/18/49 *to* 8/19 *, 19* 49 *that I last saw the deceased alive on* 8/19 *, 19* 49 *and that death occurred at* 2:15 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Wellington Dove, M. D.	1131 Eastern Ave	8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 23, 1949	Arbutus Mem. Pk.	Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Courtesy for Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave. 126

VS 150

Please write the cause of death clearly and correct age is especially important. Physician:

G77511 G77511

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): JAMES G. EHRHART

2. DATE OF DEATH: Aug. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3030 Northern Parkway
C. Length of stay in Baltimore: 40 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN: Baltimore
(If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 3030 Northern Parkway 27-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widower	Oct. 16, 1873	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Meter repair service	Gas & Elec.Co.	Penna.	USA

13. FATHER'S NAME: John Ehrhart

14. MOTHER'S MAIDEN NAME: Elizabeth Schnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	212-05-3907-A	3030 Northern Parkway Mrs.Wm. C. Medley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Infarction Myocardium due to
DUE TO Arteriosclerotic Coronary Thrombus

(B)
DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/1 1949 *to* 8/20 1949, *that I last saw the deceased alive on* 8/18 1949, *and that death occurred at* 8:40 *A.M., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Donald W. Mentzer M. D.	3209 EVERGREEN AVE	8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/23/49	Moreland Memorial	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 23 1949

REGISTRAR'S SIGNATURE: Huntington Hitchins

25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC. BALTIMORE - 13, MARYLAND

VS 150

94a

Please write the cause of death clearly and accurately. Physician: please write the cause of death clearly and accurately. Physician: please write the cause of death clearly and accurately. Physician:

X ✓

G77512

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77512

Registered No. 601

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Leith MurrAY

2. DATE OF DEATH 8-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Women's Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY BALTO.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Reisterstown
D. STREET ADDRESS (If rural, give location) Cockey's Mill Road

5. SEX F
6. COLOR OR RACE W
7. SINGLE, (MARRIED), WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 9-11-91
9. AGE (In years last birthday) 57 58
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Gamber
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Nephrolithiasis + hydronephosis, Right
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* 8-20-49, 19__, *to* 8-21-49 19__, *that I last saw the deceased alive on* 8-21-49, 19__, *and that death occurred at* 5:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE H. C. Decker M. D.
23B. ADDRESS Women's Hosp. Balt. Md
23C. DATE SIGNED 8-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug. 24'49
24C. NAME OF CEMETERY OR CREMATORY Deer Park
24D. LOCATION (City, town, or county) (State) Deer Park Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 2 1949
REGISTRAR [illegible] Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Wm. Berryman & Son, Reisterstown

VS 150

134a

G77513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77513

BIRTH NO. B. C. 48-2349

1. NAME OF DECEASED (Type or Print) Catherine Marie Wilsynski

2. DATE OF DEATH August 22, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5204 Horst Road

5B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Fe.	White	Single	10/20/48		10	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Francis Michael Wilsynski	Catherine Marie Maas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

Physician: please write the cause of death clearly and completely. Correct age is especially important.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningo-Encephalocele.

DUE TO

(B) Mongolian Idiot.

DUE TO

(C) Brain Abscess; Meningitis, chronic.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/26/ , 1948, *to* 8/22/ , 1949, *that I last saw the deceased alive on* 8/22/ , 1949, *and that death occurred at* 5:11 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. Andrew Allen, M. D.	1400 N. Caroline Street	8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-22-49.	St. Stanislaus	Baltimore, Md.

BURIAL PERMIT NO. [illegible] REGISTRAR'S SIGNATURE [illegible] LOCAL REGISTRAR

25. FUNERAL DIRECTOR — ADDRESS
George R. Weber

VS 150

157D

G77514 — BALTIMORE CITY HEALTH DEPARTMENT — G77514

CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): John F. Johnson — N-905H — 2. DATE OF DEATH: August 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: 10 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland — B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — D. STREET ADDRESS (If rural, give location): 423 Eislen St. 22-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	M	Sept. 6, 1925	23				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Sharoletsvill Va.	U.S.A.

13. FATHER'S NAME: Joseph Johnson

14. MOTHER'S MAIDEN NAME: Lillian ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Dorothy Johnson — ADDRESS: 408 Eislen St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet wounds of head, — DUE TO Chest, and left arm

ANTECEDENT CAUSES

(B)

II — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. — DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street	Found at Conway & Fremont St.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK [ ]	NOT WHILE AT WORK [X]	21F. HOW DID INJURY OCCUR?
August 20, 1949 1:20 A			Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
H. J. McClafferty M.D.	[X] / [ ] / [ ]	August 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 24. 1949	Balto. Nat. Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 23 1949 — REGISTRAR'S SIGNATURE: Washington Williams, Md

25. FUNERAL DIRECTOR — ADDRESS: Elroy C. Wilson 1000 Brantly Ave

VS 151

166

Please write the cause of death clearly and legibly. Physician: please write. Correct age is especially important.

M M. 130977 G77513

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77515

1. NAME OF DECEASED (Type or Print) Grace Owens

2. DATE OF DEATH August 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1103 Ploy ST. Z 1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	Negro	Widow	March 4 1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME Lockman ?

14. MOTHER'S MAIDEN NAME Sallie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Records Balto City Hospitals ADDRESS 4940 Eastern Av

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Uremia	
ANTECEDENT CAUSES	DUE TO (B) Arteriosclerotic heart disease	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Lung abscess	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-11 , 19 49 to 8-21 , 19 49 *that I last saw the deceased alive on* 8-21 19 49 *and that death occurred at* 1.45 PM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. B. Cooper M. D.	4940 Eastern Ave	8-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 25-49	Mt Zion Cem.	Balto, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 26 1949	Huntington Williams, M.D.	Elroy F. Wilson	1000 Bentley Rd

VS 150

937

correct age is especially important. Physician please

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. # 77434 — Registered No. 7316

1. NAME OF DECEASED (Type or Print): Elsie Pucci

2. DATE OF DEATH: 8/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp.
c. Length of stay in Baltimore: — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto. Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 9187 Lawn St. 3-02

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 5-4-[illegible]0
9. AGE (In years last birthday): 2 yr. If under 1 Year: Months, Days. If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto. M.d.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ferdinand L. Pucci
14. MOTHER'S MAIDEN NAME: Cecilia Pochmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Ferdinand L. Pucci — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Metastatic Wilm's tumor — INTERVAL BETWEEN ONSET AND DEATH
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [✓] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/10/49, 19__, *to* 8/21/49 19__, *that I last saw the deceased alive on* 8/21/49, *and that death occurred at* 12:45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leo N. Kastner, M. D.
23B. ADDRESS: % Sinai Hosp
23C. DATE SIGNED: 8/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 24-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Rd + Moravia
DATE RECEIVED BY LOCAL REGISTRAR: AUG 26 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Frank Pulla Vore — ADDRESS

VS 150

52a

Please write in the correct age is especially important. Physician, please sign.

977517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 977517

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES SHAPIRO — 2. DATE OF DEATH 8-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4013 Kathland Ave
C. Length of stay in Baltimore 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md 15-10
D. STREET ADDRESS (If rural, give location) 4013 Kathland Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married		50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant — 10B. KIND OF BUSINESS OR INDUSTRY LITHOGRAPH Co. — 11. BIRTHPLACE (State or foreign country) New York — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Morris VIFE PRES. — 14. MOTHER'S MAIDEN NAME Rose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Jenny Shapiro — ADDRESS 4013 Kathland

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 hour

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-2 1949 *to* 8-22, 1949 *that I last saw the deceased alive on* 8-20 1949 *and that death occurred at* 8P m. *from the causes and on the date stated above.*

23A. SIGNATURE Edmund Levin M. D. — 23B. ADDRESS 3400 Kelton Rd — 23C. DATE SIGNED 8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-24-49	Balto Hebrew	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 23 1949 — REGISTRAR'S SIGNATURE Washington Williams, M.D. — 25. FUNERAL DIRECTOR Jack Lewis Inc — ADDRESS 2100 Eutaw Pl

VS 150

94a

G77518

G77518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JENNIE LEVY

2. DATE OF DEATH 8-22-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1636 Moreland Ave

C. Length of stay in Baltimore 45 Yrs. ~~Mo.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-03
D. STREET ADDRESS (If rural, give location) 1636 Moreland Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married		77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Solomon

14. MOTHER'S MAIDEN NAME Anna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Joseph Levy ADDRESS 1636 Moreland Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I	(A) Cerebral Thrombosis	July 15/49
	DUE TO Arteriosclerosis.	—
	(B) Uremia	—
	DUE TO Hypertensive C.V. disease	
	(C) Generalized arteriosclerosis.	
	ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 29/49 *to* Aug. 22, 19 49 *that I last saw the deceased alive on* Aug 22, 19 49, *and that death occurred at* 1 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE W. E. Keerley M.D.
23B. ADDRESS 2314-W. North Ave
23C. DATE SIGNED 8-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8-23-49
24C. NAME OF CEMETERY OR CREMATORY Rosedale
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

VS 150

93D.

6T9229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77519

1. BIRTH NO.

2. NAME OF DECEASED (Type or Print) William T. Hudgins

2. DATE OF DEATH Aug. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital D.O.A.
C. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4336 Glenmore Ave. 26-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	Oct. 3, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder
10B. KIND OF BUSINESS OR INDUSTRY Standard Welding Co.
11. BIRTHPLACE (State or foreign country) N.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Henry Hudgins
14. MOTHER'S MAIDEN NAME Mary F. Rice
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mrs. Corinna H. Piquitt ADDRESS 4336 Glenmore Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Artery Disease	
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 21 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24B. DATE 8-24-49
24C. NAME OF CEMETERY OR CREMATORY Greenmount
24D. LOCATION (City, town, or county) Baltimore (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 23 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR G. Howard Strong ADDRESS 3207 W. North Ave.,

94a

VS 151

Cause of death age is especially important. Physician: please write the cause

G77520

BIRTH NO. G77520

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4/6 Registered No.

1. NAME OF DECEASED (Type or Print) John Sifford

2. DATE OF DEATH August 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 34 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 157 N. Decker Ave. 6-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	7-19-15	34		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mahanic	Coca Cola Co	Md.	

13. FATHER'S NAME Benjamin Sifford

14. MOTHER'S MAIDEN NAME Margaret Nicholas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
(A)	Heart failure	
DUE TO		
(B)	Rheumatic Heart Disease	
DUE TO	and	
(C)	Pneumonia	1 wk.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-20, 1949, *to* 8-21, 1949, *that I last saw the deceased alive on* 8-21, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip J. Negley M. D.	JOHNS HOPKINS HOSPITAL	8-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-25-49	New Cathedral	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949		John A. Moran	3000 E. Balt. St.

VS 150

95B

Please write plainly. Physician's special attention is especially called to the importance of correct answers to all questions.

BIRTH NO. G77521

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77521

Registered No. 53

1. NAME OF DECEASED (Type or Print): William M. Harris

2. DATE OF DEATH: Aug. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.
C. Length of stay in Baltimore: 73 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 341 East 21st St. 12-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	M.	April 18, 1876	73	4			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Retired	Maryland.	

13. FATHER'S NAME: William M. Harris

14. MOTHER'S MAIDEN NAME: Mary Jane Blizzard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown		Mrs. Alice M. Harris	341 E. 21st St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Descending Colon.
DUE TO (Ē Carcinomatosis)

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 mos

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June 1949	Carcinoma of Descending Colon	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 27, 1949 *to* Aug 21, 1949, *that I last saw the deceased alive on* Aug 21, 1949, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Alvin Bonglaer M. D.	Union Memorial Hosp.	8-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-24-49	Leister	West Minister Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Millicent, M.D.	John A. Moran	3000 E. Balt. St.

VS 150

46E

Please write plainly. Physicians: please correct age is especially important.

G77.522

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77.522

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John A. Bermel

2. DATE OF DEATH 8-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4727 Alhambra Ave

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4727 Alhambra Ave 2-7-10

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	1-12-1897	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician	Revere Copper Work	Maryland	

13. FATHER'S NAME: Floran Bermel

14. MOTHER'S MAIDEN NAME: Amelia Lotti

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	215-10-0827	Mrs Pauline T. Bermel	4727 Alhambra Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B) Chr. Arteriosclerosis
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1948 to 8-21, 1949, *that I last saw the deceased alive on* 8-20, 1949, *and that death occurred at* 3:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE O. K. Swalm M. D. | 23B. ADDRESS 36 [illegible] | 23C. DATE SIGNED 8-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-24-49	New Cathedral	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 23 1949 | REGISTRAR'S SIGNATURE [illegible] | 25. FUNERAL DIRECTOR John A. Moran | ADDRESS 3000 E. Balto. St.

VS 150

94a

Correct age is especially important. Physician: please write plainly.

G77523 G77523

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Ella B. Daily

2. DATE OF DEATH: 8/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ambassador Apts.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: -----
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-1
D. STREET ADDRESS (If rural, give location): Canterbury Rd. & 39th St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months; Days	If Under 24 Hours Hours; Min.
Female	White	Widowed	Sept. 30, 1865	83	10 21	----

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Baltimore, Md.	-------

13. FATHER'S NAME: William E. Anderson

14. MOTHER'S MAIDEN NAME: Margaret M. Woods

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
-----	----------	--------

17. INFORMANT: Frank F.J. Daily ADDRESS: 232 Homewood Ter.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
(A)	Myocardial degeneration	5 Years.
DUE TO (B)	Arterio sclerosis Senile	10 Years
DUE TO (C)	Partial bulbar Palsy	6 Years
	~~Glaucoma~~, with bladder Glaucoma	11 Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 1936 to Aug, 1949 *that I last saw the deceased alive on* Aug 21, 1949 *and that death occurred at* m., *from the causes and on the date stated above.*

SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathan R. Enright, M.D.	10 E. Biddle St.	Aug 22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/24/49	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Thomas Thompson Williams, M.D.	H. W. Mears & Son	805 N. Calvert St.

VS 150

Correct age is especially important. Please write in full.

931

G77524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E974.0

G77524

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) KARL LINDERMAN — N-991

2. DATE OF DEATH August 22, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1648 Kingsway Road 27-09

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Married	Sept. 14, 1905	43 44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mch.	Glen L. Martin's	Germany	

13. FATHER'S NAME
Karl

14. MOTHER'S MAIDEN NAME
not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Johanna Lindeman	1648 Kingsway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation

DUE TO

(B) Hanging

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	1648 Kingsway Rd.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21F. HOW DID INJURY OCCUR?
August 22, 1949 ? a.m.		Hanged self by clothesline from rod in bathroom

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE Earl L. Bruce M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED August 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/24/49	Moreland Mem. Pk.	Taylor Ave.

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR — ADDRESS
Clarence F. Hoffmann 1639 Broadway.

VS 151

164a

correct age is especially important. Physicians please write the

G77525 ✓ G77525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33 ✓

Registered No.

BIRTH NO. G77525

1. NAME OF DECEASED (Type or Print) JOHN C. MASOPUST

2. DATE OF DEATH 8/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland Funeral

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-01

c. Length of stay in Baltimore life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2918 McElderry #5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M	1/24/82	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Insurance Agent	FIRE INS. Co.	Baltimore, Md.	

13. FATHER'S NAME: Carl A. Masopust

14. MOTHER'S MAIDEN NAME: Anna Nowak

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no		Anna C. Masapust - wife	above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis — Interval between onset and death: 5 hrs.
DUE TO
(B) Arteriosclerosis, Generalized
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/22 *19*49 *to* 8/22 *19*49, *that I last saw the deceased alive on* 8/22, 19 49 *and that death occurred at* 4:20 P.M., *from the cause and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles J. Blazek, M.D.	Maryland Funeral	8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 25, 1949	Oak Hill Cemetery	Horner's Lane, Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
AUG 29 1949	Hamilton Jon Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

83B

G77526 ✓ G77526

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) GEORGE FITZBERGER

2. DATE OF DEATH August 20, 1949

3. PLACE OF DEATH: Baltimore City, Maryland 715 N. Luzerne Ave.

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

b. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 715 N. Luzerne Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Oct. 27, 1880	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
machinist	GAS APPARATUS	Baltimore, Md.	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			Mrs. Lillian Fitzberger	715 N. Luzerne Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-6-, 19[illegible], *to* 8-15, 19[illegible], *that I last saw the deceased alive on* 8-15, 19[illegible], *and that death occurred at* 7:30 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Louis Vogel Jr. M. D.	760 E. Hamburg St	8-20-49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/23/49	Baltimore Cemetery	North Ave. & Rose St.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc.	2601-3-5 E. Madison St.

VS 150

Correct age is especially important. Physician's

94a

M M G77:527 6095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77:527

0 10 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Annie Ruth Miller

2. DATE OF DEATH August 21, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 730 ½ W. Franklin ST. 10-03

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 6 Years (Yrs. Mos. Days)

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Seperated
8. DATE OF BIRTH: Jan.29,1926
9. AGE (In years last birthday): 23 Yrs (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): GA.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Harper
14. MOTHER'S MAIDEN NAME: Annie Harper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records Balto City Hospitals ADDRESS 4940 Eastern Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningitis Tuberculosis

DUE TO

(B) Miliary Tuberculosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-15- , 19 49 to 8-21-49 , 19 , *that I last saw the deceased alive on* 8-21 , 19 49 *and that death occurred at* 2 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS 4940 Eastern Ave
23C. DATE SIGNED 8-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 8-24-49.
24C. NAME OF CEMETERY OR CREMATORY MT. AUBURN
24D. LOCATION (City, town, or county) (State) BALTO., MD.

DATE RECEIVED BY LOCAL REGISTRAR 8-24-49
REGISTRAR'S SIGNATURE [signature], M.D.
25. FUNERAL DIRECTOR ADDRESS Wm. A. JACKSON - 916 PENNA. AVE.,

VS 150

13B

correct age is especially important. Physician, please

BS-125632
G77528

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77528 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lenora (Leonora) Cooper

2. DATE OF DEATH 8-21-49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto, City Hospitals
C. Length of stay in Baltimore 31 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1419 Mountmor Ct. (Henryton Sanitorium)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Married	June 5, 1918	31		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME Douglas Tyler

14. MOTHER'S MAIDEN NAME Leonora Tyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		RECORDS*BALTO. CITY HOSPITALS	EASTERN AVE.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Far advanced Pulmonary Tuberculosis	
ANTECEDENT CAUSES	DUE TO (B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-28, 1948, *to* 8-21, 1949, *that I last saw the deceased alive on* 8-21, 1949, *and that death occurred at* 8:20 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. A. Bogan M. D.	4940 Eastern Avenue	8-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-25-49	Arbutus Mem. Pk	Baltimore Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1949	Hunting for Williams	Mrs Frances A. Hemsley	518 W. Biddle st

correct age is especially important. Physician: please

VS 150

13B

G77529 X ✓ G77529

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E8.19.0

Registered No.

1. NAME OF DECEASED (Type or Print) Lena Ridcliffe N-8.29.21

2. DATE OF DEATH August 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
St. Joseph's Hospital

c. Length of stay in Baltimore none (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New York B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Bronx

D. STREET ADDRESS (If rural, give location)
936 Kelley St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widow		68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Gibson, N. C.	

13. FATHER'S NAME
Thomas Wade

14. MOTHER'S MAIDEN NAME
Sophie Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Rosie Hepron	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Multiple Fractures

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street	Belair Road & White Avenue 27/4

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
July 21, 1949 5:30 A.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Auto into safety pylon

22. *I certify that I took charge of the remains described above, held an* Autopsy ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	M.D.	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Earl L. Royer			21 Aug '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/26/49		New York, N. Y.

DATE RECEIVED BY LOCAL REGISTRAR 8-25-49 REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Chas. R. Law ADDRESS 802 Madison Ave

Correct age is especially important. Typewriter preferred.

VS 151

170c

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G77530 — Registered No. G77530

1. NAME OF DECEASED (Type or Print): Hilda Coates (HILDA COATES) — 2. DATE OF DEATH: 8/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Mercy Hosp
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 39 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-or
D. STREET ADDRESS (If rural, give location): 1522 W. Lafayette Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	Feb 20 1910	39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore	USA.

13. FATHER'S NAME: Willie Bowen

14. MOTHER'S MAIDEN NAME: Bertie Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Edgar Coates — ADDRESS: 1522 W Lafayette Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis Portal type — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/12, 1949 *to* 8/20, 1949, *that I last saw the deceased alive on* 8/20, 1949, *and that death occurred at* 526 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Richard Evans M. D.	Mercy Hosp.	8/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-23-1949	Mt. Auburn	Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Funeral Director, Williams, Md	Mrs Katie P. Williams	329 N. Schroeder St

VS 150

124B

~~G77531~~ ✓X G77531

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170

Registered No.

1. NAME OF DECEASED (Type or Print): ANTOINETTE LOUISE CHANEY

2. DATE OF DEATH: 8/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 719 East 21st Street

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): westminister
D. STREET ADDRESS (If rural, give location): 65 Pennsylvania Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	White	Married	Oct. 3, 1900	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: August Buschman

14. MOTHER'S MAIDEN NAME: Mary Purzer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: --

17. INFORMANT / ADDRESS: Mr. James Chaney, Westminister, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Recurrent Carcinoma neck, chest i obstruction — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(B) Carcinoma breast 2½ yrs ago. Operated

DUE TO

(C) Progressive lymphatic cervical + tracheal obstruction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION: Carcinoma, breast i metastases

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 5, 1949, *to* Aug 2, 1949, *that I last saw the deceased alive on* Aug 21, 1949, *and that death occurred at* 11:30A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: John B. Wells, Jr. M. D.

23B. ADDRESS: 6007 Sycamore Rd

23C. DATE SIGNED: Aug 22 '49

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE: 8/24/49

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): City

DATE RECEIVED BY LOCAL REGISTRAR: AUG 23 1949

REGISTRAR'S SIGNATURE: Registrar for Baltimore, Md.

25. FUNERAL DIRECTOR / ADDRESS: WIEDEFELD & SON, GREENMOUNT AVE & 22ND

VS 150

50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77-732 B.C. 49-17057 — E 9 21 0 — 177,932 — Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby Boy Siegel N-933

2. DATE OF DEATH: Aug 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2234 E. Balto St
C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-03
D. STREET ADDRESS (If rural, give location): 2234 E. Balto St.

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single | 8. DATE OF BIRTH | 9. AGE (In years last birthday): If Under 1 Year: Months / Days: 7 | If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): Baltimore Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Nathan | 14. MOTHER'S MAIDEN NAME: Irene

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Nathan Siegel | ADDRESS: 2234 E Balto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation due to aspiration of Stomach Content.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: — | 19B. MAJOR FINDINGS OF OPERATION: — | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2234 E. Balto St. 6/3

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 23, 1949 / 10 A.M. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? Aspirated Stomach Contents.

22. *I certify that I took charge of the remains described above, held an* Autopsy / Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: William J. Helfrich M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ / ASSISTANT MEDICAL EXAMINER ☐ / MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED: Aug 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 8-26-49 | 24C. NAME OF CEMETERY OR CREMATORY: Rosedale | 24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 23 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Jack Levin Inc | ADDRESS: 2100 Eutaw St

1951

VS 151

G77533 ✓

BALTIMORE CITY HEALTH DEPARTMENT 331 G77533

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John a Holthaus

2. DATE OF DEATH Aug 20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1729 Washington
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 8-06
D. STREET ADDRESS (If rural, give location) 1729 Washington St

c. Length of stay in Baltimore Life Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	widow	Dec 24 1879	69	7 26	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sewerage Dept	Balto City	Balto	

13. FATHER'S NAME August a Holthaus

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Albt a Holthaus	7907 Belair Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 Days.

DUE TO

(B) Arterial Hypertension — 1 year

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from July 14, 1949, to Aug 20, 1949, that I last saw the deceased alive on Aug 21 1949, and that death occurred at 8:15 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	DATE SIGNED
Albert Rinesberg M. D.	10252 North Ave	Aug 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Aug 23/49	Weems Va	Weems Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Huntington Williams, M.D.	Ward Funeral Home	2008 Orleans St

VS 150

83a

G77534

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

16

Registered No. G77534

1. NAME OF DECEASED (Type or Print) Leon Lenkowski

2. DATE OF DEATH August 23/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1708 Linden ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New Jersey B. COUNTY Franklin
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) FRANKLIN
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	Under 1 Year: Months	Days	Under 24 Hours: Hours	Min.
Male	White	Single	Feb. 8 - 1880	69	15			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Zinc Mines
10B. KIND OF BUSINESS OR INDUSTRY RUBBER Franklin N.J.

11. BIRTHPLACE (State or foreign country) Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME MACHINE OPERATOR Michael Lenkowski

14. MOTHER'S MAIDEN NAME Katherine Grohalski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Frank H. Nasfalski ADDRESS 1708 Linden Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral metastases — INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO

(B) Carcinoma of lung — 10 months

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 30, 1948 *to* Aug 23, 1949, *that I last saw the deceased alive on* Aug 1, 1949, *and that death occurred at* 630A *m., from the causes and on the date stated above.*

23A. SIGNATURE Alan Bernstein M. D. | 23B. ADDRESS 1109 N Calvert St (2) | 23C. DATE SIGNED 8/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug 25/49 | 24C. NAME OF CEMETERY OR CREMATORY Western Caem | 24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 23 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Mamie C. Syffer | ADDRESS 1600 4. Nora Ave

47D

G77535

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

151

G77535

Registered No.

1. NAME OF DECEASED (Type or Print) Thomas J. Taylor Sr.

2. DATE OF DEATH Aug 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1430 N. Bond St.

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN? (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1430 N. Bond St 8-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Male	Colored	Single	Oct. 17 1887	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	B.C. Bureau of Sanitation	Balto. Md.	

13. FATHER'S NAME Thad Taylor

14. MOTHER'S MAIDEN NAME Sarah Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Minnie Brown	1430 N. Bond St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Carcinoma (stomach) — INTERVAL BETWEEN ONSET AND DEATH 1 yr

DUE TO (B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
1 Mar 49	Carcinoma (stomach)	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 1949 to Aug 21 1949 that I last saw the deceased alive on Aug 20 1949 and that death occurred on the date stated above at 2:20 pm

23A. SIGNATURE RAYNER BROWNE, M.D.

23B. ADDRESS 1500 EAST MADISON ST. BALTIMORE 2, MD.

23C. DATE SIGNED 8-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 24/49	Arbutus M. Park	Arbutus Md.

DATE RECEIVED BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Huntington Williams, M.D.	Mrs. Robert A. Ellis & Daughter	46B 1129 N Carlton St

VS 150

G77536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4700

G77536

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John PILLER

2. DATE OF DEATH 8/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1659 St Benedict St

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-05
D. STREET ADDRESS (If rural, give location) 1659 St Benedict St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	7/19/1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Capt of Guard	Md Pen	Balto Md	

13. FATHER'S NAME John Piller

14. MOTHER'S MAIDEN NAME Barbara Sadler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		219-10-3737	Margaret A. Piller	1659 St Benedict St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24 Hours

DUE TO

(B) Arteriosclerotic Heart Disease — unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-28-47 19__, *to* 8-22-49 19__, *that I last saw the deceased alive on* 8-21-49, 19__, *and that death occurred at* 1A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathan Rosenau M. D.	206 E. Gilmor St.	8-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/24/49	New Cathedral	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Huntington Williams, M.D.	Roll & B. M. Walters	Pratt & Eutaw Sts 937

VS 150

G77537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77537 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Keye Browne

2. DATE OF DEATH: 23 Aug. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1206 John St.

C. Length of stay in Baltimore: 7 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1206 John St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	Mar. 26, 1888	61 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Building Materials	Ironton, Ohio	

13. FATHER'S NAME: Henry Richardson Browne

14. MOTHER'S MAIDEN NAME: Isabelle Peters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-		376-05-0479	Mrs. Mae S. Browne	1206 John St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Carbuncle, Posterior Cervical

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED: 23 Aug. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	8/25/59	Forest Lawn Cem.	Charlotte, N. C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Huntington Williams, MD	WM. J. TICKNER & SONS	Balto., Md.

VS 15

94a

G77538

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59

Registered No. G77538

1. NAME OF DECEASED (Type or Print): HENRY W. WORTCHE

2. DATE OF DEATH: August 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1619 W. North Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1619 W. North Ave. 15-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widower	Aug. 29, 1863	85 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer (Rtd.)	Stationary	Baltimore, Md.	

13. FATHER'S NAME: Henry Wortche

14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Mrs. Margaret Freeman	1619 W. North Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr. Valvular Heart Disease, mitral Insufficiency — Interval between onset and death: 1940

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C) Chr. Interstitial Nephritis — 1940

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 2 - 1947 *to* Aug 22, 1949 *that I last saw the deceased alive on* Aug 21, 1949 *and that death occurred at* 12 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul Brown M. D.	1163 W North Ave	8/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/24/49	Lorraine Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Tuntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

131a

G77539

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

450.0 G77539

BIRTH NO. G77539 Registered No.

1. NAME OF DECEASED (Type or Print): Harriet J. Parsons

2. DATE OF DEATH: Aug 20, 1949

3. A. PLACE OF DEATH: Baltimore City, Maryland 4129 Roland Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 45 Yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4129 Roland, Ave 13-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Fe	White	Single	Sept 3 1875	73	11	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Welfare Nurse		St Marys Co	

13. FATHER'S NAME: James T. Parsons

14. MOTHER'S MAIDEN NAME: Maria Reeder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Helen P. Thompson — ADDRESS: 4129 Roland, Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.): (A) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 19, 1949, to Aug 20, 1949, *that I last saw the deceased alive on* Aug 20, 1949 *and that death occurred at* 2 75 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William S Hefbach M. D.	5006 Roland Ave	Aug 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 23/49	Woodlawn	Woodlawn, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Carrington Williams M.D.	John O. Mitchell Sons	1900 Eutaw Pl

VS 150

97

G77540 ✓ G77540

FILE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331 Registered No.

1. NAME OF DECEASED (Type or Print): EMELIE THOMPSON GIBBS

2. DATE OF DEATH: 8-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
c. Length of stay in Baltimore: 55 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 211 OAKDALE RD 27-14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hours: Hours	If Under 24 Hours: Min.
FEMALE	WHITE	WIDOWED	SEPT 17 1868	80	11			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	NONE	WINCHESTER VIRGINIA	USA

13. FATHER'S NAME: JAMES THOMPSON

14. MOTHER'S MAIDEN NAME: VIRGINIA BAKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No.		

17. INFORMANT: Mrs. D. A. Davis - ADDRESS: 211 Oakdale Road ✓

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis, generalized

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Broncho pneumonia - terminal — 4 months

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August 20, 1949 *to* August 21, 1949, *that I last saw the deceased alive on* August 21, 1949, *and that death occurred at* 9:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Chanler Gaylord M. D.	Union Memorial Hospital	8-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	8/24/49	Loudon Park	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Huntington Williams, M.D.	Malcolm B. Mitchell	John O. Mitchell & Sons, Inc. - 1900 Eutaw Pl.

VS 150

83a

G77541

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 334

Registered No. G77541

1. NAME OF DECEASED (Type or Print): Harriet Rouse Richardson

2. DATE OF DEATH: August 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2704 Westwood Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1206 N. Calvert St. 11-01

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Sept. 11, 1872
9. AGE (In years last birthday): 76
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Harford Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John G. Rouse
14. MOTHER'S MAIDEN NAME: Henrietta Hanway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Alice M. Richardson ADDRESS: 21 E.9th St., N.Y.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Cerabral sclerosis — 2 years
DUE TO
(C) Senility

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/10/49, 19__, *to* 8/22/49, 19__, *that I last saw the deceased alive on* 8/21/49, 19__, *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1901 Eutaw Place, City
23C. DATE SIGNED: 8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 8/24/49
24C. NAME OF CEMETERY OR CREMATORY: Churchville
24D. LOCATION (City, town, or county) (State): Churchville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: AUG 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Pl.
Malton B. Mitchell

VS 150

87

G77542

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

173

Registered No. G77542

1. NAME OF DECEASED (Type or Print) HILDA REAL (or) Hilda Bauler

2. DATE OF DEATH 8/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 120 S Durham St

c. Length of stay in Baltimore 48 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 120 S Durham
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 120 S. Durham 2-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMAL	White	SEPARATED	Sept 9, 1902	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
OPERATOR	Pads	Germany	YES

13. FATHER'S NAME Frank Wiemer

14. MOTHER'S MAIDEN NAME Wiemer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	215-07-1819	Sister	120 S Durham

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of uterus & ovaries — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Hemmorhage

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
April 22, 1949	Carcinoma of uterus and ovaries	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1949, *to* August 22, 1949, *that I last saw the deceased alive on* Aug 22, 1949, *and that death occurred at* 11 45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	M. D.	23B. ADDRESS	23C. DATE SIGNED
W. R. Church		112 Chase	8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	AUG 25 1949	HOLY REDEEMER	4430 BELAIR ROAD M.D.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 23 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Duffel Bros ADDRESS: 1600 E LOMBARD ST

VS 150

48B

G77543

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77543

1. NAME OF DECEASED (Type or Print): Thomas Colvin Hughes

2. DATE OF DEATH: Aug 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 934 Braunstein Way
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. [illegible] B. COUNTY: 934 Braunstein Way
C. CITY OR TOWN: Balto. Md (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 26-34

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Married	1-8-1881	68	6	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Watchman	HOME LAUNDRY	Whiteford Md.	

13. FATHER'S NAME: Thomas H. Hughes

14. MOTHER'S MAIDEN NAME: Julia N. Morrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	214-16-3657	Emma Mary - Wife	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy Ed Inquiry *thereon and from the evidence obtained by said* ~~Autopsy~~ Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
William G. Helfrich M.D.		Aug 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
	Aug 25 49	Baltimore Cem	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Huntington Williams, M.D.	Ellwood Cemetery	937 548 Hanover Parkway

VS 151

G77544

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4201 G77547

Registered No.

1. NAME OF DECEASED (Type or Print) Genevieve Brady

2. DATE OF DEATH Aug 22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2601 Roslyn Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Nursing Home

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 15-38
D. STREET ADDRESS (If rural, give location)

5. SEX Female
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH — 1884?
9. AGE (In years last birthday) 65?
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Getz
14. MOTHER'S MAIDEN NAME Mary Burgan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Miss Nellie Wiedefeld ADDRESS 900 E. Biddle St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1945, 19__, *to* Aug 22, 19 49, *that I last saw the deceased alive on* 8/22, 19 49, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Frank L. Barranty M.D.
23B. ADDRESS 3047 St Paul St Balto Md
23C. DATE SIGNED 8/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/25/49
24C. NAME OF CEMETERY OR CREMATORY New Cathedral
24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR AUG 23 1949
REGISTRAR'S SIGNATURE Hamilton Williams, M.D.
25. FUNERAL DIRECTOR Rita Wiedefeld
ADDRESS 900 E. Biddle St

VS 150

94a

G77545

JL - 131144

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77545

1. NAME OF DECEASED (Type or Print) Vernon R. Davis

2. DATE OF DEATH 8-22-49

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 40 yrs. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) No Home

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Single	June 9, 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Va.	

13. FATHER'S NAME: John R. Davis

14. MOTHER'S MAIDEN NAME: Susie Eddy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			B. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Tuberculosis, Bronchopneumonia. Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES Yes NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-18-49, 19__, *to* Aug. 22, 1949 *that I last saw the deceased alive on* Aug. 22, 1949, *and that death occurred at* 2.30PM., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. S. Rogers M. D.	4940 Eastern Ave.	8-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 26 1949	Mt Hebron Mem	Winchester Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 23 1949	Huntington Williams, M.D.	R. E. Hale	121 E. West St

VS 150

13B

G77546

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

G77546

Registered No.

1. NAME OF DECEASED (Type or Print): JAMES M. CRONISE

2. DATE OF DEATH: Aug. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1819 W. Lanvale St.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1819 W. Lanvale St. 16-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	April 1, 1867	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Straw Hat Blocker

10B. KIND OF BUSINESS OR INDUSTRY: Townsend & Grace Co

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: (Unknown) Cronise

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT / ADDRESS: Elmer H. Cronise, 1819 W. Lanvale St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — 8 hrs

DUE TO

(B) Arteriosclerosis — 10 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 10, 1946 *to* August 22, 1949, *that I last saw the deceased alive on* August 22, 1949, *and that death occurred at* 10 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas R. Kleeman M. D.

23B. ADDRESS: 3803 Edmondson Ave

23C. DATE SIGNED: 8/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/25/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 24 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR / ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 150

83a

G77547 G77547

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170

Registered No.

1. NAME OF DECEASED (Type or Print): Josephine G. Funk

2. DATE OF DEATH: August 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1634 Normal Avenue
c. Length of stay in Baltimore: lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1634 Normal Avenue 8-05

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Nov. 19, 1895
9. AGE (In years last birthday): 53
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Sylvester Funk
14. MOTHER'S MAIDEN NAME: Ellen Henry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James Funk, 1634 Normal Avenue
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Left Breast with Metastasis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: July 1948
19B. MAJOR FINDINGS OF OPERATION: Carcinoma
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 8, 1949, *to* Aug 22, 1949, *that I last saw the deceased alive on* Aug 22, 1949, *and that death occurred at* 1:50 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas L. Worley Jr. M. D.
23B. ADDRESS: 3900 Clarinda Blvd
23C. DATE SIGNED: 8/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 8/25/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Wm. Cook, Inc.
ADDRESS: 1217 St. Paul Street

VS 150

50

G77548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77548

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): LAURA LAVINA MEINERT

2. DATE OF DEATH: 8/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Maryland Gen. Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Gen Hosp.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1314 W. Lombard St. — 19 — 03

5. SEX: F
6. COLOR OR RACE: Wht.
7. ~~SINGLE, MARRIED~~, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 1/8/1873
9. AGE (In years last birthday): 76
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Dorchester Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Riggins
14. MOTHER'S MAIDEN NAME: Susan Hutchinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: John A. Meinert 2729 Kildare Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Abdominal carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: Feb '49
DUE TO
(B) Papillary adenocarcinoma of the ovary rt — Aug 23, 49
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Feb 2 '49
19B. MAJOR FINDINGS OF OPERATION: Adenocarcinoma of the rt ovary & metastases
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-22-49, *to* 8-23-49, *that I last saw the deceased alive on* 8-23-49, *and that death occurred at* 3:05 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leslie H Walker M. D.
23B. ADDRESS: Maryland General Hosp.
23C. DATE SIGNED: 8-23-49

24A. ~~BURIAL, CREMATION, REMOVAL~~ (Specify): Burial
24B. DATE: 8/26/49
24C. NAME OF CEMETERY OR CREMATORY: Woodland Park
24D. LOCATION (City, town, or county) (State): Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Wm Gol Inc. 1217 St. Paul St

BUG VS 150

49a

G77.549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180 G77.549 Registered No.

BIRTH NO. G77.549

1. NAME OF DECEASED (Type or Print) Louis Falck

2. DATE OF DEATH 8-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto General
C. Length of stay in Baltimore 50 Yrs. Mos. Days.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28-03
D. STREET ADDRESS (If rural, give location) 4311 Norfolk ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	married		67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10B. KIND OF BUSINESS OR INDUSTRY Grocer Self
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME David
14. MOTHER'S MAIDEN NAME Chia
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Bessie Falck 4311 Norfolk Ave ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Ca of Kidney & Metastasis	Jan. '48-Aug '49
DUE TO		
(B)		
DUE TO		
(C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-16, 1949 *to* 8-23, 1949, *that I last saw the deceased alive on* 8-23, 1949, *and that death occurred at* 545 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William W. Bindeman M.D. M. D.	WBBH	8-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-24-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 24 1949	Deputy for Williams, MD	Jack Levin Inc	2100 Eutaw Pl

VS 150

52a

G77550 ✓ G77550

BIRTH NO. G77550

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 44 ✓

Registered No.

1. NAME OF DECEASED (Type or Print): Hattie Scott Boyd

2. DATE OF DEATH: 8/22/49

3. PLACE OF DEATH
A. Baltimore City, Maryland 903 Morris St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 903 Morris St
C. Length of stay in Baltimore: 27 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 903 Morris St. 11-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F	C	M.	1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home wife		Green Wood, S.C.	U.S.A.

13. FATHER'S NAME: Albert Barton

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Mamie Carter (Sister) ADDRESS: 903 Morris St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension — 2-3 yrs.

DUE TO

(C) Ulcers of Legs - Arteriosclerosis — 1-2 months

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/12, 1949, to 8/22, 1949 *that I last saw the deceased alive on* 8/20, 1949, *and that death occurred at* 2A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
N. Louise Young M. D.	1129 Druid Hill Ave	8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/24/49	Mt. Calvary Cem.	Cedar Hill Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 24 1949	Huntington Williams, M.D.	A. P. Holstead	918 Druid Hill Ave.

VS Form 1949

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH No 77551 — E 7.81.5 — Registered No. 1

1. NAME OF DECEASED (Type or Print) JAMES MASON — N-563:4

2. DATE OF DEATH August 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

C. Length of stay in Baltimore 24 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 403 N. Pearl Street — 17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	colored	Single	2/20/14	35 33		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Shipyard	Dublin, Ga.	U.S.A.

13. FATHER'S NAME Louis Mason

14. MOTHER'S MAIDEN NAME Sylvia Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-14-4120

17. INFORMANT Sylvia Mason — ADDRESS 552 W. Preston

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet wound of abdomen — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Corner of Mulberry and Pearl Streets

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 20, 1949 3.30P

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE Emil Ruppersberger, M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED August 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/24/49

24C. NAME OF CEMETERY OR CREMATORY Mount Auburn

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 24 1949

REGISTRAR'S SIGNATURE Evelyn Taylor for Matthews, M.D.

25. FUNERAL DIRECTOR Chas. F. Law — ADDRESS 802 Mad. Ave-1

VS 151

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G77552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. G77552 Registered No. 187

1. NAME OF DECEASED (Type or Print): SAMUEL CLIFFORD SPIEGEL

2. DATE OF DEATH: 8/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.
C. Length of stay in Baltimore: Yrs. 45 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Y. M. C. A. - 1800 Webster St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	July 6, 1892	57 years		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Freight Brakeman
10B. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): McKeesport, Pa.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John C. Spiegel
14. MOTHER'S MAIDEN NAME: Mary B. Borland
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Mary B. Spiegel ADDRESS: 304-4th St., Irwin, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Hemorrhagic Pancreatitis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) Pancreatitis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 7/8/49
19B. MAJOR FINDINGS OF OPERATION: Acute Hemorrhagic Pancreatitis
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/8/49, 19__, *to* 8/21/49, 19__, *that I last saw the deceased alive on* 8/23/49, 19__, *and that death occurred at* 1 AM m. *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas G. Bonney M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 8/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	8/25/49	West Newton, Pa.	West Newton, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

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G77553

BIRTH NO. B.C. 49-18091

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3 G77553
Registered No.

1. NAME OF DECEASED (Type or Print): William H. Smith

2. DATE OF DEATH: August 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: B
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3935 S. Hanover St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	Apr. 6 1875	74	4 / 16	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10B. KIND OF BUSINESS OR INDUSTRY: Automobiles
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Henry Smith
14. MOTHER'S MAIDEN NAME: Thompson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Harry Smith, ADDRESS: 101 6th Ave Be.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B)
DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-19, 1949 *to* 8-22, 1949, *that I last saw the deceased alive on* 8-22, 1949, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. J. Lahan, M. D.
23B. ADDRESS: Franklin Sq Hosp
23C. DATE SIGNED: 8-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/25/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 24 1949
REGISTRAR'S SIGNATURE: Williams, M.
25. FUNERAL DIRECTOR: James H. Tyrins
ADDRESS: 4001 Reisterstown Rd.

VS 15B

931

G77554 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 434

G77554 — Registered No.

1. NAME OF DECEASED (Type or Print): GRACE A. GROVES

2. DATE OF DEATH: August 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2617 Loretta Avenue
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2617 Loretta Avenue 70-0 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	Married	8/19/1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOme	Home	Port Deposit	USA

13. FATHER'S NAME: Charles P. Brown

14. MOTHER'S MAIDEN NAME: Elizabeth Haines

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO	NO	NO

17. INFORMANT: Hweitt D. Grove — ADDRESS: 2617 Lauretta Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestive Heart
DUE TO Failure
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: August 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/26/49	Elmwood	Shepardstown West Virg.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949
REGISTRAR'S SIGNATURE: Christopher Williams, MD

25. FUNERAL DIRECTOR — ADDRESS: J.T. Stansbury 2700 Edmondson Ave.

VS 151.

93E ✓

Gr. Nipchfield
6919 Harford Rd.
G77555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 4 G77555 Registered No.

BIRTH NO. G77555

1. NAME OF DECEASED (Type or Print) Eugene H. Ross

2. DATE OF DEATH Aug. 21-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5440 Belair Rd.
Gardenville Nursing Home
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-07
D. STREET ADDRESS (If rural, give location) 2903 Clearview Avenue

5. SEX male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH June 20-1894 | 9. AGE (In years last birthday) 55 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yeoman | 10B. KIND OF BUSINESS OR INDUSTRY MARITIME

11. BIRTHPLACE (State or foreign country) Baltimore Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John H. Ross

14. MOTHER'S MAIDEN NAME Elizabeth Milk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Mary L. Ross | ADDRESS 2903 Clearview

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Left Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 2 mos
DUE TO APOPLEXY
(B) Cerebral and Renal Arterio-Sclerosis — 1 year
DUE TO
(C) Chronic Myocarditis — 6 mos ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Basilar Pneumonitis due to Pan-Coug. — 2 mos

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 27 1949 to Aug 21 1949 that I last saw the deceased alive on Aug 20 1949, and that death occurred at 7:01 p m., from the causes and on the date stated above.

23A. SIGNATURE John H. Randolph Collins M.D. | 23B. ADDRESS 6919 Harford Rd | 23C. DATE SIGNED 8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8-25-49 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Cathedral | 24D. LOCATION (City, town or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 24 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Leonard J. Luck - 5305 | ADDRESS Harford

931

VS 150

BIRTH NO. G77556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77556 46 Registered No.

1. NAME OF DECEASED (Type or Print): CLARENCE EDWARD VAUGHN

2. DATE OF DEATH: Aug. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 701 N. Calvert St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	1/15/16	33		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver	JUNK (SELF)	Md.	USA

13. FATHER'S NAME: Leonard Vaughn

14. MOTHER'S MAIDEN NAME: Mildred Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	VA 2	218-07-8141	Records- US Marine Hospital, Balto, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of nasopharynx with — Interval between onset and death: Unknown

DUE TO

metastases to liver

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* July 20, 1949 *to* Aug. 23, 1949 *that I last saw the deceased alive on* Aug. 23 1949, *and that death occurred at* 7:20 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Medical Director	US Marine Hospital, Balto, Md.	8/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/26/49	Baltimore Bath Cem	5501 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 1949		John J Cowen & Son	2 Hollins St.

VS 150

45F

077557

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

193

077557
C 77557
Registered No.

1. NAME OF DECEASED (Type or Print): Jennie P. Atkinson

2. DATE OF DEATH: Aug. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-7
D. STREET ADDRESS (If rural, give location): 526 W. University Parkway

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 15, 1893
9. AGE (In years last birthday): 55 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fort Payne, Alabama
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Price
14. MOTHER'S MAIDEN NAME: Esther Van Dyke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): -
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Son, W.S.Atkinson, III
ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Medullary pressure conus — INTERVAL BETWEEN ONSET AND DEATH: 10 min.
DUE TO
ANTECEDENT CAUSES
(B) malignant (cora) Brain tumor, rt. tempora lobe, type undetermined — 3 wks.
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-22- , 1949, *to* 8-23- , 1949, *that I last saw the deceased alive on* 8-23- , 1949, *and that death occurred at* 5:15 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Green, III M. D.
23B. ADDRESS: Union Memorial Hosp.
23C. DATE SIGNED: 8-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-24-49
24C. NAME OF CEMETERY OR CREMATORY: St. Thomas
24D. LOCATION (City, town, or county) (State): Garrison Forest, Md.

DATE RECEIVED BY LOCAL REGISTRAR: 8-24-49
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Frank H. Newell
ADDRESS: Pikesville, Md.

VS 150

543

BIRTH NO. G77558 G77-85945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 7.0 G77558

Registered No.

1. NAME OF DECEASED (Type or Print) Master John N. White (Name)

N-255.0

2. DATE OF DEATH 8/23/49 August 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 313 Mt. Holly St. 21-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	8/9/47	2 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Md.	—

13. FATHER'S NAME: Carl H. White

14. MOTHER'S MAIDEN NAME: May E. Birkett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT: May E. White — ADDRESS: 313 Mt. Holly St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) 1. Acute cerebral edema
DUE TO 2. Compression of spinal cord
3. Dislocation of 3rd cervical vertebrae

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 9 hr.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Grandfather's Home	Pasadena, Maryland Home of John N. White

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 22, 1949 10:30 P.M.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Child rolled over father's legs, turned somersault and landed on floor

22. *I certify that I took charge of the remains described above, held an* Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B.	23C. DATE SIGNED
Earl L. Bruce M.D.	CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	August 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 26, 1949	Woodlawn	Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 24 1949	Acting for Registrar	Mr. & Mrs. John W. Teufel & Son	5311 Edmondson Ave.

VS 151

195E

G77559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77559

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth Fischbacke

2. DATE OF DEATH Aug. 22, 49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - Catonsville
D. STREET ADDRESS (If rural, give location) 19 Delevan ave. DEL REY

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) —
8. DATE OF BIRTH 9/4/1881
9. AGE (In years last birthday) 67
If Under 1 Year: Months 10 Days 24
If Under 24 Hours: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME William Ray
14. MOTHER'S MAIDEN NAME Ellen Ryan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT — ADDRESS —

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute liver Failure
DUE TO
(B) Hepatoma (Extensive)
DUE TO
(C) —

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 8/19/49
19B. MAJOR FINDINGS OF OPERATION Hepatoma - Extensive.
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 8/12/49, 19__, *to* 8/22/49, 19__, *that I last saw the deceased alive on* 8/22/49, 19__, *and that death occurred at* 6:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Carlton T. Hall Jr. M. D.
23B. ADDRESS St. Agnes Hospital.
23C. DATE SIGNED 8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/25/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION (City, town, or county) (State) Baltimore, Md.
DATE RECEIVED BY LOCAL REGISTRAR AUG 24 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR AND ADDRESS Easton Sons - Catonsville

VS 130

57E Md.

G77560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0 G77560 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): NELLIE B MOERSDORF

2. DATE OF DEATH: AUG 23 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6719 HUDSON ST
C. Length of stay in Baltimore: WIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MARYLAND.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 6719 HUDSON ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	MARRIED	MAY 7 1892	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE	AT HOME	BALTIMORE	U.S.A.

13. FATHER'S NAME: AUGUST ELLER BROCK

14. MOTHER'S MAIDEN NAME: ANNA E. HOLZHEID

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO	—	NONE

17. INFORMANT: GEORGE MOERSDORF ADDRESS: 6719 HUDSON ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Valvular heart disease — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(B)
DUE TO
(C) Arterio-sclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from Aug 20, 1949, to Aug 23, 1949, that I last saw the deceased alive on Aug 23, 1949, and that death occurred at 10A. m. from the causes and on the date stated above.

23A. SIGNATURE	M. D.	23B. ADDRESS	23C. DATE SIGNED
Chas. T. Schmitt		1001A Dundalk Av.	Aug 23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	AUG-26-49	HOLY REDEEMER	4400 BELAIR RD MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 24 1949	Huntington Williams, M.D.	DIPPEL BROS.	1800 E. LOMBARD ST

VS 150

93D

✓ Daehnke

G7756X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1949

77561 Registered No.

BIRTH NO. B.L.-H-07285

1. NAME OF DECEASED (Type or Print) Master Raymond W. Daehnke Jr

2. DATE OF DEATH 8/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital
c. Length of stay in Baltimore 5 Yrs. 8 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3061 Stafford St. 20-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	8-14-1944	5				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Raymond W. Daehnke Sr.
14. MOTHER'S MAIDEN NAME Helen Murphy
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO —
17. INFORMANT Hospt RECORDS ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Metastatic tumor liver — INTERVAL BETWEEN ONSET AND DEATH 2

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B) Neuroblastoma, adrenal (primary gland)
DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 7/20/49
19B. MAJOR FINDINGS OF OPERATION Metastatic tumor liver
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/26, 1949, to 8/22, 1949, that I last saw the deceased alive on 8/21, 1949, and that death occurred at 5304 m., from the causes and on the date stated above.

23A. SIGNATURE J. Ramsey M. D.
23B. ADDRESS St. Agnes Hosp.
23C. DATE SIGNED 8/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	Aug 25-49	MX Olivet	Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: AUG 24 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Edward Finlson ADDRESS 2359 Gwynn Oak Blvd Balto 30 Md

VS 150

#5a

G77562

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77562

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Kiel

2. DATE OF DEATH: 8.24.49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

C. Length of stay in Baltimore: 24 hrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Howard
C. CITY OR TOWN: Ellicott City
If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): Columbia Pike Ellicott City. Md

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W.	S.	8.23.49				24	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Mr. Charles Kiel

14. MOTHER'S MAIDEN NAME: Violet Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Chas W Kiel ADDRESS: Ellicott City Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8.23.49, 19xx, *to* August 24, 1949, *that I last saw the deceased alive on* August 24, 19xx, *and that death occurred at* 1 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. J. Castellano M. D. | 23B. ADDRESS: Bon Secours Hospital. | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/25/49	Good Shepherd	Ellicott City Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 24 1949

REGISTRAR'S SIGNATURE: Washington Williams, M.D.

25. FUNERAL DIRECTOR: J.C. Higginbotham ADDRESS: Ellicott City Md.

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G77563

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 G77563
Registered No.

1. NAME OF DECEASED (Type or Print): HARRY E. SHAW

2. DATE OF DEATH: 8/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. Genl Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: a. a.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Linthicum Heights
D. STREET ADDRESS (If rural, give location): 320 E Maple Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: 5/27/898
9. AGE (In years last birthday): 51
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: U.S. Rubber Co
11. BIRTHPLACE (State or foreign country): Balto - Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert Shaw
14. MOTHER'S MAIDEN NAME: Hanna Alcott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W. W. #1
16. SOCIAL SECURITY NO.
17. INFORMANT: Lillian Shaw ADDRESS: 320 Maple Road Linthicum Heights

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL Hemorrhage
DUE TO
(B) Hypertension Cardio-Vasc. Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/22/49 9:30 PM *to* 8/22/49 8:50 PM, *that I last saw the deceased alive on* 8/22, 1949, *and that death occurred at* 8:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John H. Bernard M. D.
23B. ADDRESS: S. B. G. H.
23C. DATE SIGNED: 8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/25/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town, or county) (State): Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Bork Inc.
ADDRESS: 217 St. Paul St.

93D

G77564

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77564 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth A. Otto

2. DATE OF DEATH: August 22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2512 E Hoffman St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): None
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 2512 E Hoffman St
B. COUNTY Baltimore Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 2512 E Hoffman St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Sept. 18- 1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	✓	Baltimore Md	USA

13. FATHER'S NAME: Andrew Kind

14. MOTHER'S MAIDEN NAME: Margaret Wiegand

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	✓	Chas. M. Otto	2512 E Hoffman St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 da 4 days
DUE TO
(B) Arteria Sclerosis + Hypertension — 1 yr
DUE TO
(C) Chronic Interstitial Nephritis — 1 yr

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
None		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* August 14, 1949 *to* August 22, 1949, *that I last saw the deceased alive on* Aug 22, 1949 *and that death occurred at* 11 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
T. A. Stevens M. D.	2878 Harford Rd	8-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-25-49	Balto. Cemetery	North Ave. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 24 1949	Huntington Williams, M.D.	John J. Miller, Inc.	2435 E. Oliver St

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CERTIFICATE CORRECTED 8-30-49

G77565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77565

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary CAROL Suttle

2. DATE OF DEATH: Aug. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore (over) 27-12
D. STREET ADDRESS (If rural, give location): 346 Cudowood Lane, Lo. Towson

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Sep.
8. DATE OF BIRTH: 5-10-20
9. AGE (In years last birthday): 29 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis J. Lewis Herzog
14. MOTHER'S MAIDEN NAME: Helen Mullahy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Post operative lobectomy right upper and middle.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 8/20/49
19B. MAJOR FINDINGS OF OPERATION: Tuberculus cavity.
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/13/49 *to* 8/23/49, *that I last saw the deceased alive on* 8/23, 1949, *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE: Gordon Malone Carver Jr.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 8/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: AUG. 26-1949
24C. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL
24D. LOCATION (City, town, or county) (State): BALTIMORE, MD

DATE RECEIVED BY LOCAL REGISTRAR: AUG 24 1949
REGISTRAR'S SIGNATURE: [illegible] Williamsville, Md
25. FUNERAL DIRECTOR: Chas. G. Evans & Son Inc.
ADDRESS: 118 N. Mt. Royal Ave. 13B

G77566 G77566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Henry Hawkins

2. DATE OF DEATH Aug 21 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 4422 St. Georges Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE

B. COUNTY 27-10

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City Md

D. STREET ADDRESS (If rural, give location) 4422 St. George Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Married		71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Laborer	Balto Co. Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nicholas Hawkins	Francis ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Florence Hawkins	4422 St George Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility

DUE TO

(B) constant hard work

DUE TO Very vigorous constitution

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) —

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis Potmark

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Natural

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 16th, 1949 to Aug 21, 1949 *that I last saw the deceased alive on* Aug 21, 1949, *and that death occurred at* 9 p. m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. Goodhart M. D.	351 W. Biddle St	Aug 24, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 25 1949	Pleasant Rest	Towson Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 24 1949	Huntington Williams, M.D.	Robert E Williams	1515 McElderry St

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BALTIMORE CITY HEALTH DEPARTMENT 43 G77567

BIRTH NO.

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) GEORGE BRINDLE PARKS

2. DATE OF DEATH August 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Somerset
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Crisfield
D. STREET ADDRESS (If rural, give location) 620 Main St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	? 1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Master	Seafarer	Va.	USA

13. FATHER'S NAME Major Parks

14. MOTHER'S MAIDEN NAME Atline Evans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Unknown		?	Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 20 1949, *to* Aug. 24, 1949, *that I last saw the deceased alive on* Aug. 24, 19 49 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
S. Conway Ford, M. D.	US Marine Hospital, Balto, Md.	8/24/49

24A. ~~BURIAL, CREMATION~~ REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Removal	8-25-49.	TANGIER-VA.	VIRGINIA.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 25 1949	Huntington Williams, M.D.	BRADSHAW FUNERAL HOME. (CRISFIELD, MARYLAND). 93

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G77568 G77568

BIRTH NO. H-98295

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 293

Registered No.

1. NAME OF DECEASED (Type or Print): Gloria Ann Nice

2. DATE OF DEATH: August 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-9
D. STREET ADDRESS (If rural, give location): 1311 Wirton Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	9/7/1943	5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Howard Nice
14. MOTHER'S MAIDEN NAME: Elizabeth Callahan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Howard Nice ADDRESS: 1311 Wirton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Terminal bronchopneumonia
DUE TO
(B) Anemia, severe, cause undetermined.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 22, 1949 *to* August 23, 1949 *that I last saw the deceased alive on* August 23, 1949 *and that death occurred at* 6:55A m., *from the causes and on the date stated above.*

23A. SIGNATURE: S. K. Kaan M. D.
23B. ADDRESS: St. Joseph's Hospital
23C. DATE SIGNED: 8-23-49

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify)	24B. DATE	24C. NAME OF CEMETERY ~~OR CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	8/26/49	Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

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Hospital Disposal

BIRTH NO. B.C. 49-1885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

760 5

Registered No. G77569

1. NAME OF DECEASED (Type or Print): Baby Girl (B) Lappe

2. DATE OF DEATH: Aug. 5 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2303 Garrett Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 8-4-49
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George Lappe
14. MOTHER'S MAIDEN NAME: Ethel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intracranial hemorrhage
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/4 *, 1949, to* 8/5 *, 1949, that I last saw the deceased alive on* 8/5 *, 1949, and that death occurred at* 9 P.M. *, from the causes and on the date stated above.*

23A. SIGNATURE: Willard W. Waring M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Hosp. Disposal
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

160a

G77570

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 355

G77570

Registered No.

1. NAME OF DECEASED (Type or Print): SHIRLEY LEE SHRIEVES

2. DATE OF DEATH: AUG. 23 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3408 WILKENS AVE
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 25-41
D. STREET ADDRESS (If rural, give location): 3408 WILKENS AVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	SINGLE	OCT. 17 1934	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: BERLIE M SHRIEVES
14. MOTHER'S MAIDEN NAME: EDNA M NEARY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MR. BERLIE M SHRIEVES
ADDRESS: 3408 WILKENS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH. (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Progressive Cerebral Degeneration Acute Infarcts (Status Demyelinisatus ?) — INTERVAL BETWEEN ONSET AND DEATH: About 1½ yrs

DUE TO

(B)

DUE TO

(C) Dyomyelinosatis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1949 *to* Aug 22, 1949 *that I last saw the deceased alive on* Aug 22, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Abram Goldman, M. D.	206 S. Gilmor St.	Aug 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	AUG 25 '49	LOUDON PARK	BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 25 1949	Emerson Williams, M.D.	HARRY H. WITKE - 4101 EDMONDSON	AVE

VS 150

87E

G77571 Hospital Disposal

BIRTH NO. B.C.49-17265

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1675

Registered No. G77571

1. NAME OF DECEASED (Type or Print): Baby Boy Chester (Beatrice)

2. DATE OF DEATH: Aug 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days 2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-1
D. STREET ADDRESS (If rural, give location): 1201 N. Eden St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored		8-15-49			2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Chester
14. MOTHER'S MAIDEN NAME: Beatrice Chester

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Neonatal Anoxia — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

DUE TO

(B) Atelectasis

DUE TO

(C) Prematurity

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 15, 1949 *to* Aug 17, 1949, *that I last saw the deceased alive on* Aug 17, 1949, *and that death occurred at* 3:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 8.19.49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Hof of Deposal
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: ADDRESS

VS 150

159

~~B-3711172~~ G77572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~874572~~ 776 Registered No.

BIRTH NO. B.C.49-18147

1. NAME OF DECEASED (Type or Print): Baby Boy Hinton-Twin B

2. DATE OF DEATH: Aug.17-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-4
D. STREET ADDRESS (If rural, give location): 615 Brice St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Mins.
M	Negro	Single	Aug. 17-1949			15 / 15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Hinton

14. MOTHER'S MAIDEN NAME: Elizabeth Horton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): Baltimore City Hosprtals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-17- , 1949 PM *to* 8-17- , 1949, *that I last saw the deceased alive on* 8-17- , 1949, *and that death occurred at* 11.30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Bozan M. D.

23B. ADDRESS: 4940 Eastern Ave.

23C. DATE SIGNED: 8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated

24B. DATE: August 19-1949

24C. NAME OF CEMETERY OR CREMATORY: Baltimore City Hospitals

24D. LOCATION (City, town, or county) (State): 4940 Eastern Ave., Balto., Md. ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR

VS 150

159

AB-131118
77573
BIRTH NO. B. C. 49-18146

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 776

G77573
Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Hinton-Twin A.

2. DATE OF DEATH: Aug. 17- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-4
D. STREET ADDRESS (If rural, give location): 615 Brice St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Negro	Single	Aug. 17-1949			10 05

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Maryland	

13. FATHER'S NAME: Henry Hinton

14. MOTHER'S MAIDEN NAME: Elizabeth Horton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Records- Baltimore City Hospitals 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ No. ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-17- , 1949 *to* 8-17- , 1949 *that I last saw the deceased alive on* 8-17- , 1949 *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
[signature]	4940 Eastern Ave.	8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremated	Aug. 19-1949	Baltimore City Hospitals	4940 Eastern Ave., Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 25 1949	Huntington Williams, M.D.	

VS 150

159

G77574 ✓ 420.1 G77574

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Lena Salinsky

2. DATE OF DEATH: 8/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai
C. Length of stay in Baltimore: 42 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 15-11
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4000 Hilton Road

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH
9. AGE (In years last birthday): 60 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Isadore
14. MOTHER'S MAIDEN NAME: Ida

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Sam Salinsky ADDRESS: 4000 Hilton Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Coronary Occlusion
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypertension, Diabetes

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/24, 19 49 to 8-25, 19 49 that I last saw the deceased alive on 8-25, 19 49, and that death occurred at 1:20 A m., from the causes and on the date stated above.

23A. SIGNATURE: Jerome Galen M. D.
23B. ADDRESS: Sinai Hosp.
23C. DATE SIGNED: 8/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-26-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State): Dalto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949
REGISTRAR'S SIGNATURE: Acting for Williams, M.D.
FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

61

G775575

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 976.0 G775575

Registered No.

1. NAME OF DECEASED (Type or Print): IRVIN BERNSTEIN

2. DATE OF DEATH: August 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-16
D. STREET ADDRESS (If rural, give location): 4424 Pallmall Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	SINGLE	SEPT 1930	19		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SALESMAN	ADVERTILING	BALTO MD	U.S.A

13. FATHER'S NAME: OSCAR

14. MOTHER'S MAIDEN NAME: GRACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO		

17. INFORMANT: OSCAR BERNSTEIN — ADDRESS: 4424 Pall Mall Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet Wound of Brain — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	4424 Pallmall Road

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 24, 1949 ?A m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Ruth Boyer M.D.		24 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8-25-49	HEBREW FRIENDSHIP	BALTO MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
AUG 25 1949	Huntington Williams, M.D.	Jack Lewis Inc. - 2100 Eutaw Pl

164c

77576 ✓ G77576

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 44 ✓

Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM EDWARD FARRAR

2. DATE OF DEATH: Aug. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4506 Frederick Rd. Colonial Nursing & Conv. Home
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 27-4
D. STREET ADDRESS (If rural, give location): 4431 Old Frederick Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widowed	Sept. 29, 1857	91 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter (Retired)	SELF	Virginia	

13. FATHER'S NAME: William E. Farrar

14. MOTHER'S MAIDEN NAME: - Tyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Mrs. Ruby C. Peetz	- 4431 Old Frederick Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Degenerative Cardiovascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) Acute Congestive failure — 8/24/49
DUE TO
Senility.
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY Ooccur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 27 July, 1949, *to* 24 Aug., 1949 *that I last saw the deceased alive on* 24 Aug, 1949, *and that death occurred at* 14A m. *from the cause and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph E. Muse Jr. M. D.	5 West 29th St.	8/24/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or County) (State)
Burial	8/26/49	Western Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 25 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

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Mul
G77577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 1 G77577 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Emma Richardson Jones

2. DATE OF DEATH August 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 206 Oakdale Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) none

c. Length of stay in Baltimore 72 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-14
D. STREET ADDRESS (If rural, give location) 206 Oakdale Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	widowed	Jan. 25, 1860	89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Centerville, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Samuel Anthoney Richardson

14. MOTHER'S MAIDEN NAME Susan Straughn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Mrs. Van V. Klinefelter-206 Oakdale Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) General arteriosclerosis — 3 years
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1 1948, *to* Aug 23, 1949, *that I last saw the deceased alive on* Aug 23, 1949, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Wilbur F. Buchman M. D. | 23B. ADDRESS 6 E. Biddle St. | 23C. DATE SIGNED 8/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8 - 25 - 49	Druid Ridge	Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR AUG 25 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS John O. Mitchell & Sons, Inc. - 1900 Eutaw Place

Malcolm B. Mitchell

94a

G77578

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 491

Registered No. G77578

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VIRGINIA TUDOR

2. DATE OF DEATH August 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ~~Provident~~ City Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 4-2
D. STREET ADDRESS (If rural, give location) 123 North Pearl Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	Oct 26, 1869	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Virginia	U.S.A.

13. FATHER'S NAME Arch Coghill

14. MOTHER'S MAIDEN NAME Ann Thomas ✓

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT Mrs Blanche Quasney ADDRESS 1701 Hanover

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Carl L Rogers M.D.		August 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 26, 1949	Cedar Hill	Annapolis Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 25 1949	Huntington Williams, M.D.	John J Kenny Inc	715 Light

VS 151

107

~~77579~~ H- 131168 BALTIMORE CITY HEALTH DEPARTMENT 6-5 677579

BIRTH NO. B.C. 49-19082 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Heard "A" - Bessie

2. DATE OF DEATH: 8-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 2 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-1
D. STREET ADDRESS (If rural, give location): 1011 Ensor St.

5. SEX: F
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug. 18, 1949
9. AGE (In years last birthday) If Under 1 Year: Months / Days: 2 If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Eddie Lee Hayes
14. MOTHER'S MAIDEN NAME: Bessie Heard
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS: Balt. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congental Atelectasis
DUE TO
(B) Prematurity.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ No ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 18, 1949, *to* Aug. 20, 1949 *that I last saw the deceased alive on* Aug. 20, 1949, *and that death occurred at* 4.20PM, *from the causes and on the date stated above.*

23A. SIGNATURE G. S. Dozier M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: B. C. H. Crematory
24D. LOCATION (City, town, or county) (State): 4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

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G77580

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

S41.0

G77580

Registered No.

1. NAME OF DECEASED (Type or Print) DUDLEY DAY LAWTON

2. DATE OF DEATH 7-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Calvert & 33 Sts

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP.

C. Length of stay in Baltimore LIFETIME Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALT.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 27-14
D. STREET ADDRESS (If rural, give location) 4709 ROLAND AVE.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	WHITE	MARRIED	6-1-1870	79	2	22	—	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE BROKER
10B. KIND OF BUSINESS OR INDUSTRY Real Estate
11. BIRTHPLACE (State or foreign country) BALTIMORE - MD.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIAM T. LAWTON
14. MOTHER'S MAIDEN NAME NATALIE DAY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO	NO	108-01-7110

17. INFORMANT Mrs. Ruth C. Lawton (wife) ADDRESS 4709 Roland Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) BLEEDING DUODENAL ULCER — INTERVAL BETWEEN ONSET AND DEATH 24 Hrs
DUE TO
(B) ARTERIOSCLEROSIS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 7-24-49
19B. MAJOR FINDINGS OF OPERATION ACTIVE DUODENAL ULCER
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-23, 1949, *to* 7-27, 1949, *that I last saw the deceased alive on* 7-24, 1949, *and that death occurred at* 12:55 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Henry Charles Hirshfeld M. D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 8-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-24-49	Druid Ridge	Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Stewart Memorial - Balto. ADDRESS

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77581 JL- 129953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

00 ✓

G77581 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Brandford (Bentford)

2. DATE OF DEATH 8-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore
D. STREET ADDRESS (If rural, give location) 771 Dover St 21-1

5. SEX M

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Wid.

8. DATE OF BIRTH 1886

9. AGE (In years last birthday) 63 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper

10B. KIND OF BUSINESS OR INDUSTRY LABORER - UPHOLSTERING SHOP

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joe Brandford

14. MOTHER'S MAIDEN NAME Mary Elizabeth Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT B. C. H. Records, 4940 Eastern Ave. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 27, 1949, *to* Aug. 23, 1949, *that I last saw the deceased alive on* Aug. 23, 1949 *and that death occurred at* 10.20 AM *from the causes and on the date stated above.*

23A. SIGNATURE P. S. Rogers M. D.

23B. ADDRESS 4940 Eastern Ave.

23C. DATE SIGNED 8-24, -49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/26/49

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 25 1949

REGISTRAR'S SIGNATURE Lauriston Williams, M.D.

25. FUNERAL DIRECTOR A. Halstead

ADDRESS 917 Druid Hill Avenue 1360

VS 150

77582

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77582

Registered No.

1. NAME OF DECEASED (Type or Print) OLIVIA BALLARD

2. DATE OF DEATH 8/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 307 N. Biddle St.
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 307 N. Biddle St. 11-3

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored		1898	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10B. KIND OF BUSINESS OR INDUSTRY PRIVATE FAMILY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Chas. Ballard ADDRESS 307 W. Biddle

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE John R Ward M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED 8/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/26/49	Mt. Auburn Cemet.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 25 1949	Huntington Williams, M.D.	A. Halstead	918 Druid Hill Ave. 93D

VS 151

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G77583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

411 Registered No. G77583

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Robert Suesse

2. DATE OF DEATH AUG 24 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sparrows Pt.
D. STREET ADDRESS (If rural, give location) 7401 Bayfront Road #19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	White	married	11-2-17	31				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck driver		Md.	U.S.

13. FATHER'S NAME August Suesse

14. MOTHER'S MAIDEN NAME Ellen Smith ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.			JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
DUE TO
(B) Aortic stenosis
DUE TO
(C) Rheumatic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-20- 1949 *to* 8-24- 1949 *that I last saw the deceased alive on* 8-24- 1949 *and that death occurred at* 4:34 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip D. Nugent M. D.	JOHNS HOPKINS HOSPITAL	Aug 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	AUG. 26 1949	OAK LAWN	EASTERN BLVD BALTO. CO. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 25 1949	Remington Williams, M.D.	Roland L. Fisher	Dundalk, Md.

92c

G77584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G77584

1. NAME OF DECEASED (Type or Print): JOSEPH E. BRIGHTFUL

2. DATE OF DEATH: 8/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
c. Length of stay in Baltimore: 14 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): UNION BRIDGE
D. STREET ADDRESS (If rural, give location): Rural

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	widowed	Nov. - 1862	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Day	Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Hooper Brightful	Mary Brightful

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		None	Ernest Brightful	Union Bridge Md.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIOSCLEROTIC CVD and probable CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) BENIGN PROSTATIC HYPERTROPHY

DUE TO

(C) VESICLE CALCULI

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-15-49	large calculi	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-25, 19 49 *to* 8-25, 19 49 *that I last saw the deceased alive on* 8-25, 19 49 *and that death occurred at* 4:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hubert K. Spears, M. D.	University Hospital	8-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 28-49	Glasswerk Cem.	Taylorsville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 25 1949	Huntington Williams, M.D.	H. O. Fairbourn & Sons	Union Bridge & New Windsor, Md.

VS 150

1343

G77585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17

G77585 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANNA GIESEMAN

2. DATE OF DEATH Aug 23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 620 W Cross St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. 70 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 620 W Cross St 21-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed		70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME J. GIESEMAN.

14. MOTHER'S MAIDEN NAME Anna Hart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Doran ADDRESS 620 W Cross St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis (diffuse metastasis) — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(B) Primary site unknown probably cervix — 1 yr +

DUE TO

(C) Generalized arterio-sclerosis — 10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none		

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/12, 1949, to 8/23, 1949, *that I last saw the deceased alive on* 8/23, 1949, *and that death occurred at* 2.05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Dr. Maurice Feldman Jr. M. D.	817 St Paul St	8/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 26 49	London Park	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 25 1949	Twentyton Williams, M.D.	Bernard Hecht	1000 S Para St

VS 150

48a

G77586

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

175

G77586

Registered No.

1. NAME OF DECEASED (Type or Print) Kathryn D. Timm

2. DATE OF DEATH Aug 24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2036 Clynwood
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore Yrs. 46 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2036 Clynwood ave

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Aug 10-1902
9. AGE (In years last birthday) 47 46
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse
10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME Harry Timm
14. MOTHER'S MAIDEN NAME K. Buckley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-10-3434

17. INFORMANT Lillian Timm ADDRESS 2036 Clynwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of right lung and Larynx. — 2 weeks
DUE TO
(B) Carcinoma of left ovary and fallopian tube — 3 Mos.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION May 10, 1949
19B. MAJOR FINDINGS OF OPERATION Carcinoma of left ovary & tube.
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 6, 1949 *to* Aug. 24, 1949, *that I last saw the deceased alive on* Aug. 23, 1949, *and that death occurred at* 5 A. *m., from the causes and on the date stated above.*

23A. SIGNATURE Albert G. Bringman M.D.
23B. ADDRESS 1613 E. North Ave., Balto.
23C. DATE SIGNED 8-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 27-49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State) Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Bernard Hecht ADDRESS 1000 S Bond St

VS 150

49a

GM. 77587 131198

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 77587

1. NAME OF DECEASED (Type or Print): Mabel W. Wainer

2. DATE OF DEATH: 8- 24- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: 16-3
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1606 Edmondson Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	Married	March 9 1903	46Yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		MD.	

13. FATHER'S NAME: Elijah Pandexter

14. MOTHER'S MAIDEN NAME: Fannie Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Records B.C.H.	4940 Eastern Ave.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident

DUE TO

(B) Hypertensive Cardio Vascular Renal Disease

DUE TO

(C)

ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes Mellitus

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 8- 18- , 1949 *to* 8- 24- , 1949, *that I last saw the deceased alive on* 8- 24- 1949 *and that death occurred at* 2.45Am m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. L. Thayer M. D.	B.C.H. 4940 Eastern Ave.	8-24-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	8-27-49	Western Star	Catonsville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 25 1949	Huntington Williams, M.D.	Samuel W. Sullivan Jr.	1011 N. Arlington Ave 61

VS 150

G77588

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. G77588 Registered No. 443

1. NAME OF DECEASED (Type or Print): Hymen Hakins (Himan Hanking)

2. DATE OF DEATH: August 24-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-3
D. STREET ADDRESS (If rural, give location): 634 N. Gilmore St.

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: ?-?-?
9. AGE (In years last birthday): 60? If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): S.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Adam Hakins
14. MOTHER'S MAIDEN NAME: Dora Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT (Address): Baltimore City Hospitals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Hypertensive Cardiovascular Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-16 , 1949 *to* 8-24 , 1949 *that I last saw the deceased alive on* 8-24 , 1949 *and that death occurred at* 7.20 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: C. B. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 8-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: 8-29-49
24C. NAME OF CEMETERY OR CREMATORY: Bals National
24D. LOCATION (City, town, or county) (State): Balto. City

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Samuel W. Sullivan Jr. ADDRESS: 1011 N. Arlington Ave 937

VS 150

Dr. Cook
2436 Eutaw Ave
7383

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

731 Registered No. G77589

1. NAME OF DECEASED (Type or Print): Theresia M. Ackerman

2. DATE OF DEATH: Aug 23 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1913 Eutaw Place
Twilight Nursing Home

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-3
D. STREET ADDRESS (If rural, give location): 1913 Eutaw Place

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aged
9. AGE (In years last birthday): 70 — If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Harry Kohlerman — ADDRESS: 1405 Fidelity Bldg.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1949, *to* August 23, 1949, *that I last saw the deceased alive on* Aug. 21 1949, *and that death occurred at* 6:00 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: E. Elkaroth M. D.
23B. ADDRESS: 2431 Maryland Ave.
23C. DATE SIGNED: 8/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-26-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Kuck — ADDRESS: 5305 Harford Rd.

VS 150

83a

177590 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 910.5 G77590 Registered No.

1. NAME OF DECEASED (Type or Print): Dominick Torre

2. DATE OF DEATH: August 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: 35 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-1
D. STREET ADDRESS (If rural, give location): 141 Front St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 4/12/1892
9. AGE (In years last birthday): 57
If Under 1 Year: Months: 4 Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman
10B. KIND OF BUSINESS OR INDUSTRY: Bldgs Rd. Cons.
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Torre
14. MOTHER'S MAIDEN NAME: Pasqua ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-03-8492
17. INFORMANT: Mrs Dominic Torre ADDRESS: 141 N. Front St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fractured cervical vertebrae, with compression of spinal cord.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Eastern Ave. & Angelsea Sts. (Peter D'Adamo & Sons) Employer
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: August 24, 1949 1 P m.
21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? Crushed by falling object 26/6

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: August 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. 27-1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Rd. & Moravia Ave.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Frank Della Vecchia ADDRESS

VS 151

195E

G77591

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

G77591

Registered No.

1. NAME OF DECEASED (Type or Print) LEWIS GOLDEN

2. DATE OF DEATH 8/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5241 ParkHeights Ave 27-17

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Oct 8, 1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Package Liquor Store		Baltimore Md	

13. FATHER'S NAME: Abraham Goldstein

14. MOTHER'S MAIDEN NAME: Rebecca Ogruek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Ida Golden ADDRESS 5241 ParkHeights Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident or Pulmonary Embolism

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Virus Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-22, 1949 *to* 8-23, 1949 *that I last saw the deceased alive on* 8-23, 1949, *and that death occurred at* 8 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Leonard Kotz M. D. | 23B. ADDRESS Sinai Hosp | 23C. DATE SIGNED 8/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Aug 26, 1949	Hebrew Herring Run Cem	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Sol Levinson & Bros ADDRESS 1126 W North Ave

VS 150

83a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77592 BIRTH NO.

Registered No. 77592

1. NAME OF DECEASED (Type or Print): Harry Adler

2. DATE OF DEATH: 8/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 10-1
D. STREET ADDRESS (If rural, give location): 302 W Biddle St

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1885
9. AGE (In years last birthday): 64
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Merchandise
10B. KIND OF BUSINESS OR INDUSTRY: Store

11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis Adler
14. MOTHER'S MAIDEN NAME: Esther ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Raymond Adler — ADDRESS: 302 W Biddle St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: P. L. Sulomiski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 8/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 26, 1949
24C. NAME OF CEMETERY OR CREMATORY: Oheb Shalom Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

VS 151

94a

G77593

JL - 123394

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

490

G77593

Registered No.

1. NAME OF DECEASED (Type or Print) William Lehnhoff

2. DATE OF DEATH 8-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore
(If outside corporate limits, write RURAL and give township) 27-10
D. STREET ADDRESS (If rural, give location) 4448 Wrenwood Ave, Govans- 12

5. SEX M

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Nov. 6, 1868

9. AGE (In years last birthday) 80
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cigar Maker

10B. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Francis W. Lehnhoff

14. MOTHER'S MAIDEN NAME Mary Harps

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT B. C. H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
Dr J. McClafferty, MD
for: C.J.Lubinski, M. D.
CHIEF OR ASST. MEDICAL EXAMINER

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION Oct. 6, 1948

19B. MAJOR FINDINGS OF OPERATION Reduction & pinning of left hipc Smith Peterson Nail

20. AUTOPSY? YES ☐ No ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Fractureofleft Femur

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) At Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4448 Wrenwood Ave.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept. 24, 1948 m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? fell on pavement

22. *I hereby certify that I attended the deceased from* 9-30-48, 19__, *to* Aug. 23, 1949, *that I last saw the deceased alive on* Aug. 23, 1949, *and that death occurred at* 8AM *m., from the causes and on the date stated above.*

23A. SIGNATURE C. S. Logan M. D.

23B. ADDRESS 4940 Eastern Ave.

23C. DATE SIGNED 8-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE 8-26-49

24C. NAME OF CEMETERY OR CREMATORY PARKWOOD

24D. LOCATION (City, town, or county) BALTIMORE (State) Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 25 1949

REGISTRAR'S SIGNATURE Tentatively Williams, M.D.

25. FUNERAL DIRECTOR John A. Moran

ADDRESS 900 E. Balt. St.

To be approved by Medical Examiner

VS 150

118

G77594 31085

CERTIFICATE CORRECTED 8-26-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

7573

G77594

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Moore Baby girl Inez

2. DATE OF DEATH: 8-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-2
D. STREET ADDRESS (If rural, give location): 307 N. Carey St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro	New Born	8-15-49			12 / 3

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Willie Pearson
14. MOTHER'S MAIDEN NAME: Inez Moore
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Records Balto City Hospitals Eastern Ave ADDRESS 4940

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital malformations of the Kidneys — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Prematurity- Congenital Atelectasis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-15-49, 19__ *to* 8-15-49, 19__, *that I last saw the deceased alive on* 8-15-49, 19__, *and that death occurred at* 8.15 8.30 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE: O. B. Bozeman M. D.
23B. ADDRESS: 4940 Eastern Ave
23C. DATE SIGNED: 8-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremated	Aug. 17-1949	Baltimore City Hospitals	4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

157H

77595

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 677595

1. NAME OF DECEASED (Type or Print) Elizabeth Brandt

2. DATE OF DEATH Aug 24th 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland 1233 N. Gay St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto 8-7
D. STREET ADDRESS (If rural, give location) 1233 N. Gay St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	April 24th 1879	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Glenzer
14. MOTHER'S MAIDEN NAME Elizabeth Leibno
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Wm Brandt 1233 N. Gay St ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — Interval between onset and death: 1 hr.
DUE TO
(B) Arteriosclerosis — 5 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10 1948 *to* August 24 1949, *that I last saw the deceased alive on* [redacted] *and that death occurred at* 9:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Ernest Lenz, M.D. M. D. — 23B. ADDRESS 1605 N. Broadway — 23C. DATE SIGNED 8/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 27th 1949	Parkwood	Taylor Ave.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949
REGISTRAR'S SIGNATURE: Emmington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Leo S. Leach 1701-03 N. Patterson Park ave

VS 150

94a

G77596 ✓ X 331 G77596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 77596

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JESSIE GARY BLACK

2. DATE OF DEATH: Aug. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cockeysville
D. STREET ADDRESS (If rural, give location): Mt. Pleasant Farm

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Jan. 12, 1876
9. AGE (In years last birthday): 73 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James A. Gary
14. MOTHER'S MAIDEN NAME: Lavina Cory

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Alec Bullock, ADDRESS: Brooklynville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
(B) Cerebral Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 21, 1949 *to* Aug. 24, 1949, *that I last saw the deceased alive on* Aug. 24, 1949, *and that death occurred at* 4:15P *m., from the causes and on the date stated above.*

23A. SIGNATURE: William A. Bowson M.D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 8-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug. 26, 49
24C. NAME OF CEMETERY OR CREMATORY: Lowdon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR, ADDRESS: Henry W. Jenkins & Sons Co, 4905 York Rd.

VS 150

83-a

G77597

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓x 451

Registered No. G77597

1. NAME OF DECEASED (Type or Print): Mrs. Rhuanna F. Roberts

2. DATE OF DEATH: 24 Aug. '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: 50? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westminster
D. STREET ADDRESS (If rural, give location): Willis St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Oct. 20, 1874	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James H. Tambrill

14. MOTHER'S MAIDEN NAME: ? Staley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. A. P. Pendleton ADDRESS: 710 Wyndhurst Ave Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Retroperitoneal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: app. 6 days

DUE TO

(B) Rupture of aneurysm of abdominal aorta

DUE TO

(C) Atherosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 19 Aug., 1949 *to* 24 Aug., 1949, *that I last saw the deceased alive on* 24 Aug 1949, *and that death occurred at* 8:15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm L. Green M. D.

23B. ADDRESS: Union Memorial Hosp.

23C. DATE SIGNED: 8-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Aug 26/49

24C. NAME OF CEMETERY OR CREMATORY: Mt Olivet

24D. LOCATION (City, town, or county) (State): Frederick Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Henry N. Jenkins Son & ADDRESS: 4905 York Rd

VS .150

96

G77598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77598

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Beckwith, Miss Anne V.

2. DATE OF DEATH 24 August '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital
c. Length of stay in Baltimore 66 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Zone 18 9-7
D. STREET ADDRESS (If rural, give location) 1564 Carswell St.

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH 22 May 1883
9. AGE (In years last birthday) 66 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HouseKeeper
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Horace C. Beckwith
14. MOTHER'S MAIDEN NAME Margaret Hayes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-07-3083
17. INFORMANT George Beckwith ADDRESS 1564 Carswell St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Increased intracranial pressure — INTERVAL BETWEEN ONSET AND DEATH 2 wks.
DUE TO
(B) Unknown cause
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive cardiovascular disease. Unknown

19A. DATE OF OPERATION 22 May 1949
19B. MAJOR FINDINGS OF OPERATION Increased intracranial pressure.
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) No.
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 19 Aug., 1949 *to* 24 Aug., 1949 *that I last saw the deceased alive on* 24 Aug, 1949, *and that death occurred at* 12:05 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE Wayne N. Jacobus, M.D. M. D.
23B. ADDRESS Church Home & Hosp.
23C. DATE SIGNED 24 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug. 27-1949
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Chas. J. Evans & Son
ADDRESS 118 N. Mt. Royal Ave 937

VS 150

77599 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 1 Registered No. 77599

1. NAME OF DECEASED (Type or Print) HARRY WORTH Herman John Wirth,

2. DATE OF DEATH 8/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTO GEN HOSP

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Marylamd
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3908 Boarman Ave., 15-10

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan.28,1883
9. AGE (In years last birthday) 66 If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ConstructionForman
10B. KIND OF BUSINESS OR INDUSTRY Gas&Elect.Co.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gustave Wirth,
14. MOTHER'S MAIDEN NAME Mary Reddiman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS Mrs.KatherineWirth,3908BoarmanAve.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ACUTE MYOCARDIAL INFARCT
DUE TO
(B) ASCUD[illegible] FAILURE
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/24 *19*49 *to* 8/25 *, 19*49 *that I last saw the deceased alive on* 8/25 *, 19*49 *and that death occurred at* 6:20 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE L. N. Golombek M. D.
23B. ADDRESS WB 6th
23C. DATE SIGNED Aug 25-1949

24A. BURIAL, CREMATION, REMOVAL (Specify) burial
24B. DATE Aug.27,1949
24C. NAME OF CEMETERY OR CREMATORY Holy Reddemer Cem.
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 25 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR L. V. Lemmon
ADDRESS 4611 Park Hgts.Ave.

150 L. N. Golombek, MD. 937

G77600

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77600

1. NAME OF DECEASED (Type or Print): John Louis Broll Sr.

2. DATE OF DEATH: 8/24/49

3. PLACE OF DEATH
A. Baltimore City, Maryland: BALTIMORE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1209 E. Chase St.
c. Length of stay in Baltimore: 39 Yrs. 7 Mos. 27 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE CITY
D. STREET ADDRESS (If rural, give location): 1209 E. Chase St. 10-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	MARRIED	Dec. 27 1889	59	7 27	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Jobbing	BALTIMORE	U.S.A.

13. FATHER'S NAME: John L. Broll

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		214-03-2938	Mrs. C. M. Broll	1209 E Chase St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary infarction

DUE TO

(B) Acute Pulmonary infarction

DUE TO

(C) Generalized arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/2, 1948 *to* 8/24, 1949, *that I last saw the deceased alive on* 8/24, 1949, *and that death occurred at* 5:30 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. L. Bornstein M. D.	704 E. Biddle St	8/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-27-1949	Holy Redeemer	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 25 1949	Deputy for Williams, M.D.	Elmer W. Conklin	924 E Eager St.

VS 150

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G77601

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

760 G77601 Registered No.

1. NAME OF DECEASED (Type or Print): Adeline W. Russell

2. DATE OF DEATH: August 24/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3570 N. Hilton Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shriners Nursing Home

C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-3
D. STREET ADDRESS (If rural, give location): 37 S. Stricker Street

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1/19/72
9. AGE (In years last birthday): 77 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Granville Co N. C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James Webb.
14. MOTHER'S MAIDEN NAME: Kate Russell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. William H. Russell — ADDRESS: 37 S. Stricker St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Decubitus Ulcer — 3 days
DUE TO
(C) Senility, Marasmus — 3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 22, 1949, to Aug 24, 1949, that I last saw the deceased alive on Aug 24, 1949, and that death occurred at 945 P m., from the causes and on the date stated above.

23A. SIGNATURE: Thos F. A. Stevens M. D. — 23B. ADDRESS: 2898 Harford Rd — 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation — 24B. DATE: August 26/49 — 24C. NAME OF CEMETERY OR CREMATORY: London Park — 24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 26 1949 — REGISTRAR'S SIGNATURE: Entitled to Williams, M.D. — 25. FUNERAL DIRECTOR: Loring Byers — ADDRESS: 345 W. Hoffman Ave

VS 150

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G77602

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77602

Registered No.

1. NAME OF DECEASED (Type or Print): MARY E. REISTETTER

2. DATE OF DEATH: Aug. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1636 N. Calvert St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-5
D. STREET ADDRESS (If rural, give location): 1636 N. Calvert St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Mar. 1, 1865
9. AGE (In years last birthday): 84 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George M. Reisetter
14. MOTHER'S MAIDEN NAME: Josephine Jamar
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Mrs Bertha Webb, 1636 N. Calvert St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute dilatation of heart — INTERVAL BETWEEN ONSET AND DEATH: 1 dy

DUE TO

(B) acute Coronary infarction — 3 dys

DUE TO

(C) arteriosclerosis generalized

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1941, *to* 8/25, 1949, *that I last saw the deceased alive on* 8/25, 1949, *and that death occurred at* 6 a *m., from the causes and on the date stated above.*

23A. SIGNATURE: S C Feldman, M. D.
23B. ADDRESS: 1440 E. Balt St.
23C. DATE SIGNED: 8/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/27/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1217 St. Paul St.

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G77603

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77603

1. NAME OF DECEASED (Type or Print): HILLIAN Ely

2. DATE OF DEATH: 8-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3713 Beehler Ave
C. Length of stay in Baltimore: 35 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 27-18
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3713 Beehler Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (Last birthday) 78 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Israel
14. MOTHER'S MAIDEN NAME: Lena

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Julius Ely ADDRESS: 3031 W Garrison

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(B) Arteriosclerotic Heart disease — 5 yrs
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 1, 1945, *to* Aug 25, 1949, *that I last saw the deceased alive on* Aug. 25, 1949, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Manuel Levin M. D.
23B. ADDRESS: 4818 Reisterstown Rd
23C. DATE SIGNED: Aug 26 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-26-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt. Carmel
24D. LOCATION (City, Town, or county) (State): Dalto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

93D

G77604

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

151

Registered No. G77604

1. NAME OF DECEASED (Type or Print) Henry G. Ermer

2. DATE OF DEATH Aug. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1719 Forest Park Ave.,
c. Length of stay in Baltimore 65 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28-3
D. STREET ADDRESS (If rural, give location) 1719 Forest Park Ave.,

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	April 11, 1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Furniture Repairman	Self	Baltimore, Md.	

13. FATHER'S NAME: Anton Ermer

14. MOTHER'S MAIDEN NAME: Anna Exner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	Mrs. Lizzetta Ermer	1719 Forest Prk. A

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cancer of Stomach + Bowel.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 months

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June 1949	Obstruction + Cancer Both	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 2.15 1949 *to* Aug 24, 1949 *that I last saw the deceased alive on* Aug 23, 1949, *and that death occurred at* 2.15 *a. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. C. Smith M. D.	4609 Liberty Hgts	8/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-26-1949	Lorraine Park	Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 26 1949	Huntington Williams, MD	G. Howard Strong	3207 W. North Ave.,

VS 150

46 B

G77605 CERTIFICATE CORRECTED 9-15-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4201

G77605

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) FRANCIS XAVIER RATAJSKI (SMITH)
(~~SMITH~~), ~~Francis~~ Xavier

2. DATE OF DEATH 8-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital, Baltimore 13
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 9-8
D. STREET ADDRESS (If rural, give location) 2457 Greenmount Ave, Baltimore 18 MD.

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH 12/3/~~94~~ 95
9. AGE (In years last birthday) ~~54~~ 53 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Phila. Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Andrew Ratajski
14. MOTHER'S MAIDEN NAME Catherine Plachta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 171-10-5523
17. INFORMANT Frances T. Conan ADDRESS 2542 E. York St. Phila. Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Peripheral Circulatory failure
DUE TO
(B) Acute Coronary Thrombosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE S. K. Kaan M. D.
23B. ADDRESS St. Joseph's Hospital
23C. DATE SIGNED 8-25-49

24A. ~~BURIAL, CREMATION~~ REMOVAL (Specify) Removal
24B. DATE 8/26/49
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State) Phila. Pa.

DATE RECEIVED BY LOCAL REGISTRAR AUG 26 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR Wm. J. Tichner & Son Inc
ADDRESS Wash. & Pa. Aves Balto 17, Md. 94a

VS 150

77606

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77606

Registered No.

1. NAME OF DECEASED (Type or Print) Agnes Williams

2. DATE OF DEATH Aug 24 1949

3. PLACE OF DEATH:
A. Baltimore City Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 W. Preston St

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived at institution; residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-2
D. STREET ADDRESS (If rural, give location) 39 W. Preston St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	widow.	Oct 28, 1862	86yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	—	Maryland	U.S.

13. FATHER'S NAME Wm. Howard

14. MOTHER'S MAIDEN NAME Geneva Tanger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT John O. Williams ADDRESS 915 W. 38th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic CVD

DUE TO

(B) Decompensation

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: 2

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-17, 1949 to 8-24, 1949, that I last saw the deceased alive on 8-24, 1949, and that death occurred at 2 p. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lawrence J. Shimanek M. D.	3711 Falls Rd	8-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 27/49	St. Mary's, Homeden - Roland Ave. City.	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 26 1949	Cuthbert Williams, M.D.	Eustin E. Donovan	3818 Roland Ave

VS 150

Lawrence J. Shimanek

93D

G77607

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77607

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles Parks, Jr.

2. DATE OF DEATH 8-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
C. Length of stay in Baltimore Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore md 13-6
D. STREET ADDRESS (If rural, give location) 3412 Kennedy Rd.

5. SEX M
6. COLOR OR RACE W-N
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 4-25-41
9. AGE (In years last birthday) 8 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles Parks, Sr.
14. MOTHER'S MAIDEN NAME Christine Cushing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Charles Parks Sr. ADDRESS Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) TBC meningitis — INTERVAL BETWEEN ONSET AND DEATH 5 months
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-25-49, 19__, to 8-24, 19 49, *that I last saw the deceased alive on* 8-24, 19 49 *and that death occurred at* 6 30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Dan Bowers Jr. M. D.
23B. ADDRESS Mercy Hosp
23C. DATE SIGNED 8-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 27/49
24C. NAME OF CEMETERY OR CREMATORY Lorraine Park
24D. LOCATION (City, town, or county) (State) Windsor Mill Road md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 26 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR Gustin E. Donovan
ADDRESS 3818 Roland Ave

VS 150

14

G77608

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77608 Registered No. 175

1. NAME OF DECEASED (Type or Print) MYRTLE ALVERTA SHERIDAN

2. DATE OF DEATH Aug. 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL

C. Length of stay in Baltimore 56 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 13-7
D. STREET ADDRESS (If rural, give location) 3901 FALLS RD. #1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married	FEB. 26, 1893	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife	—	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
CHARLES EVANS	CORA BOND

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		CHARLES E. SHERIDAN	SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma ovary
DUE TO C metastasis

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: one year

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Dec. 15, 1948	Papillary Carcinoma Ovary	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/21, 1949 *to* 8/25, 1949 *that I last saw the deceased alive on* 8/25, 1949, *and that death occurred at* 11 25 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank G. Ghrold, M. D.	Md. General Hospital	8/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 29-49	Druid Ridge	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 26 1949	Huntington Williams, M.D.	Frank W. Seitz	819 W 36th St

VS 150

49a

G77609

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4221 4221

G77609 Registered No.

1. NAME OF DECEASED (Type or Print) Mrs. BARBARA KATHERINE OBERLE

2. DATE OF DEATH 8-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY City 9-7
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore-18 Md.
D. STREET ADDRESS (If rural, give location) 1772 Montpelier Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	married	3-29-1876	73	4	27	###	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore	USA

13. FATHER'S NAME: Moritz Nickol

14. MOTHER'S MAIDEN NAME: Anna Marie Schrenker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	None	None

17. INFORMANT: Mr. Seraphin Oberle ADDRESS: 1772 Montpelier St Baltimore, Md.

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peritoneal hemorrhage

DUE TO

(B) due to rupture of vessel of omentum

DUE TO

(C) Arteriosclerotic condition - vessel

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-19, 19[illegible] *to* 8-25, 19[illegible] *that I last saw the deceased alive on* 8-25, 19[illegible], *and that death occurred at* 8:10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. Andrew Reece, M. D.	St. Joseph's Hospital	8-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-29-49	Most Holy Redeemer Cemetery	Belair Rd. Balto:Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 26 1949	Huntington Williams, M.D.	George J. Ruth, Inc.	1735 Harford Avenue

VS 150

93D

G77610

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77610

Registered No.

1. NAME OF DECEASED (Type or Print) Dr. Harry G. Jones

2. DATE OF DEATH August 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2818 St. Paul Street

C. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 12-6
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2818 St. Paul Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	July 10, 1881	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Physician	PRIVATE PRACTICE	Maryland	U S A

13. FATHER'S NAME: John Edwin Jones

14. MOTHER'S MAIDEN NAME: Laura Virginia Laughton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
nO	—	—

17. INFORMANT: Mrs. N. Rosina Jones ADDRESS: 2818 St. Paul Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Occlusion	Probably None
DUE TO		
(B)	1st attack Coronary occlusion	8 mo. 4 days
DUE TO		
(C)	Atypical Pneumonia	6 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 20, 1948, *to* Aug. 24, 1949, *that I last saw the deceased alive on* Aug 23, 1949, *and that death occurred at* 5A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lloyd E. Taylor M. D.	3902 Greenmount Ave.	Aug 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Entombment	Aug. 27, 1949	Lorraine Park Mausoleum	Baltimore Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 26 1949	Tuttington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

VS 150

94a

7611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

540 D G77611

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Emma Eleason Emma M. Eliason

2. DATE OF DEATH 24 Aug 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto Gen Hosp.
c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28-4
D. STREET ADDRESS (If rural, give location) 4313 Rokeby Road

5. SEX F
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH Sept. 29, 1879
9. AGE (In years last birthday) 69
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10B. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Hissey
14. MOTHER'S MAIDEN NAME Unknonw
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT (Son) ADDRESS 4313 Mr. Stanley E. Eliason, Rokeby Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Jaundice Ulcers
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
2wks approx

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY Yes Partial

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/13 19 49, to 8/24 19 49, *that I last saw the deceased alive on* 8/24 19 49, *and that death occurred at* 8:55 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Joseph Shear M. D.
23B. ADDRESS West Balto Gen Hosp
23C. DATE SIGNED 8/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug. 27/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park, 3801 Frederick Rd.
24D. LOCATION (City, town, or county) (State) Balto. 29, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 26 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Harry H. Reitz
ADDRESS 4101 Edmondson Ave.

VS 150

1170

BIRTH NO. G77612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G77612

1. NAME OF DECEASED (Type or Print): MARY CECELIA DELCHER

2. DATE OF DEATH: Aug 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp.
C. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore Parkville
D. STREET ADDRESS (If rural, give location): 3002 Moreland Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1/6/1884
9. AGE (In years last birthday): 65 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John O'Connor
14. MOTHER'S MAIDEN NAME: — Kehoe
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/15/44 19 -, *to* 8/24, 1949 *that I last saw the deceased alive on* 8/24, 1949, *and that death occurred at* 11:35 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Dunisti M. D.
23B. ADDRESS: St. Joseph's Hosp.
23C. DATE SIGNED: 8/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/27/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): 4500 Old Fred'k Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 26 1949
REGISTRAR'S SIGNATURE: Hunter Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street

VS 150

83a

G77613 G77613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Bertha Helen Wienecke

2. DATE OF DEATH August 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
c. Length of stay in Baltimore Life. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 8-1
D. STREET ADDRESS (If rural, give location) 3523 Lyndale Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	MARRIED	July 29, 1901	48				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		BALTIMORE, MARYLAND	U. S.

13. FATHER'S NAME: Rudolph Bollard

14. MOTHER'S MAIDEN NAME: MARY SVETAK.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO		

17. INFORMANT: Edward Wienecke ADDRESS: 3523 Lyndale Ave

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs 15 min
DUE TO
(B) Hypertension - Essential
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 23, 1949, *to* Aug 24, 1949, *that I last saw the deceased alive on* Aug 24, 1949, *and that death occurred at* 12 M A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Luttel, Jr. M. D.	Mercy Hosp.	8/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/27/49	Oak Lawn	Eastern Ave. Rd., Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 26 1949	Huntington Williams, M.D.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

83a

G77613 ✓ G77614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Henry Williams

2. DATE OF DEATH Aug. 25 '49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 107 S. Dallas

C. Length of stay in Baltimore 42 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 107 S. Dallas 2-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Wid.	Mar. 30 1897	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Accomac Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Williams

14. MOTHER'S MAIDEN NAME Anna Drummond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Pauline Williams ADDRESS 107 S. Dallas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

DUE TO

(B) Acute Nephritis — 1 week

DUE TO

(C) Chr. Nephritis — 6 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 17, 1949 *to* Aug 25, 1949 *that I last saw the deceased alive on* Aug 25, 1949 *and that death occurred at* 1:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE— M. D.	23B. ADDRESS	23C. DATE SIGNED
Wm. L. Berry	1420 E. Chase	Aug 25 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	Aug 29 '49	Baltimore National	Baltimore	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
8 29 49	Huntington Williams, M.D.	Robert E. Wilkerson	937 1/2-15 McElderry St

G77615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77615 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Edward Blake

2. DATE OF DEATH August 24th 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1317 Madison Avenue

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22-1
D. STREET ADDRESS (If rural, give location) 819 Leadenhall Street

Bur. - Well - Ba Funeral Home

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	C	W	Sept. 1, 1893	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	MFG. Paper Boxes	Baltimore, Maryland	U. S. A.

13. FATHER'S NAME William E. Blake, Sr.

14. MOTHER'S MAIDEN NAME Sadie A. Wallace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Williams ADDRESS 1317 Madison Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Renal — INTERVAL BETWEEN ONSET AND DEATH 6 mos.

DUE TO

(B) Disease — Hypertensive

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 1st, 1949 *to* August 22nd, 1949, *that I last saw the deceased alive on* August 22nd, 1949, *and that death occurred at* 1:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE Robert L. Jackson, M.D. (E. Zitt) M. D. | 23B. ADDRESS 600 N. Carlington Avenue | 23C. DATE SIGNED 8-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug 27 1949 | 24C. NAME OF CEMETERY OR CREMATORY Mt Auburn | 24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 26 1949 | REGISTRAR'S SIGNATURE Tuntington Williams, M.D. | 25. FUNERAL DIRECTOR Isaiah K. Brown Son | ADDRESS 108 W Monty omery St

VS 150

1314

77616

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

381.0 G77616

Registered No.

1. NAME OF DECEASED (Type or Print) Ernest E. Oliphant

2. DATE OF DEATH Aug. 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 616 E. 34th. St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN Baltimore - 18 (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) 616 E. 34th. St. 9-3

E. Length of stay in Baltimore 45 Yrs. ~~Mos.~~ ~~Days~~

5. SEX M

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Dec. 17, 1903

9. AGE (In years last birthday) 45 If under 1 Year: Months Days If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Officer

10B. KIND OF BUSINESS OR INDUSTRY Police Dept.

11. BIRTHPLACE (State or foreign country) Maryland (Balto.)

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jerome N. Oliphant

14. MOTHER'S MAIDEN NAME Julia Elliott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. -

17. INFORMANT Mrs. Vearl M. Oliphant ADDRESS 616 E. 34th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema

DUE TO

(B) Cardiac Failure

DUE TO

(C) Hepatic cirrhosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 20, 1949 to Aug. , 1949 *that I last saw the deceased alive on* Aug. 24, 1949 *and that death occurred at* 4:00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE Daniel Hope Jr. M. D.

23B. ADDRESS 3315 Westerwald Ave. Balto. 18

23C. DATE SIGNED Aug. 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/27/49

24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.

24D. LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 26 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR WM. J. TICKNER & SONS

ADDRESS Balto., Md.

VS 150

124 R

G77617

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 120.0 G77617

Registered No.

1. NAME OF DECEASED (Type or Print): MARY ELLA RESPESS

2. DATE OF DEATH: Aug. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 814 Woodington Rd.
c. Length of stay in Baltimore: 1 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township) 16-8
D. STREET ADDRESS (If rural, give location): 814 Woodington Rd.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Sept. 20, 1865
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.: 83 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis Powell
14. MOTHER'S MAIDEN NAME: Lucie Morgan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mr. Virgil N. Respess ADDRESS: 816 Woodington Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Thrombosis	1 hour
DUE TO (B)	arteriosclerosis	2 years
DUE TO (C)	old age.-	

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE, (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 5, 1948, to August 25, 1949, that I last saw the deceased alive on Aug 25, 1949, and that death occurred at 2 20 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Edith. Mortimer Jr M. D.
23B. ADDRESS: 2706 St Paul St
23C. DATE SIGNED: 8/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 8/27/49
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State): Gwynn Island, Va.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 26 1949
REGISTRAR'S SIGNATURE: Tunstall Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

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77618

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77618
Registered No.

1. NAME OF DECEASED (Type or Print) Anna Wagner

2. DATE OF DEATH August 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3-01
D. STREET ADDRESS (If rural, give location) 326 Hennings Ct.

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 10-20-28.
9. AGE (In years last birthday) 20 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Melvin Manley
14. MOTHER'S MAIDEN NAME Thelma Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia, RUL, RML, RLL, LUL, LLL, organism
(B) undetermined
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) —
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 8-24 1949 *to* 8-25 1949, *that I last saw the deceased alive on* 8-25 1949, *and that death occurred at* 8:05 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Edythe M. Schwenker M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 8/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/26/49
24C. NAME OF CEMETERY OR CREMATORY Defonce
24D. LOCATION (City, town, or county) Defonce (State) Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 26 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wilson & Dorsey ADDRESS 1217 E. Pratt St

VS 150

108

77619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77619

Registered No.

IRTH NO.

1. NAME OF DECEASED (Type or Print) SARAH E. BROWN

2. DATE OF DEATH 8/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 606 S. Green st.

C. Length of stay in Baltimore 20 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 22-2
D. STREET ADDRESS (If rural, give location) 606 S. Green st

5. SEX Female
6. COLOR OR RACE Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH — 1900
9. AGE (In years last birthday) 49
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home
10B. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Richmond - Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Moses Brooks
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Ida Childs ADDRESS 606 S Green

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocardial - [redacted]

DUE TO

(B) Hypertension myocarditis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/20, 1949 *to* 8/26, 1949, *that I last saw the deceased alive on* 8/26, 1949 *and that death occurred at* 8:33 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE David Srumlen M. D.
23B. ADDRESS 122 W. Lee st
23C. DATE SIGNED 8/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) B
24B. DATE 8-31-49
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemty
24D. LOCATION (City, town, or county) (State) Balto.

DATE RECEIVED BY LOCAL REGISTRAR AUG 26 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Walter B. Spriggs
ADDRESS 139 W. Hamburg St.

VS 150

937

G77620

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

450.0 G77620

Registered No.

1. NAME OF DECEASED (Type or Print) — GEORGE GLASCOE

2. DATE OF DEATH — August 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — 12 N. Durham Street

C. Length of stay in Baltimore — Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — Maryland
B. COUNTY
C. CITY OR TOWN — Baltimore
(If outside corporate limits, write RURAL and give township) — 6-4
D. STREET ADDRESS (If rural, give location) — 12 N. Durham Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Male	Colored	Married	Jan. 2 1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Balto. Md.	U.S.A.

13. FATHER'S NAME — John Glascoe

14. MOTHER'S MAIDEN NAME — Veiroqua Ross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT — Hattie Kelley — ADDRESS — 12 N. Durham St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteri-Sclerosis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE — Earl L. Royster M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED — 8-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 29.49	Mt Calvery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 26 1949	Huntington Williams, M.D.	Elroy O. Wilson	1000 Brantly Ave.

VS 151

97

G77621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

'49 Registered No. G77621

BIRTH NO. B.C. 48-18362

1. NAME OF DECEASED (Type or Print) Gwindola Floyd

2. DATE OF DEATH August 24/1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 1 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-3
D. STREET ADDRESS (If rural, give location) 511 N. Callington Ave.

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Child
8. DATE OF BIRTH 6-27-48
9. AGE (In years last birthday) 1 yr
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Floyd
14. MOTHER'S MAIDEN NAME Anna Endres ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. NONE

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocarditis — 4 days
DUE TO
ANTECEDENT CAUSES
(B) Pneumonia
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-23, 1949, to 8-24, 1949, *that I last saw the deceased alive on* 8-24, 1949, *and that death occurred at* 8 21 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE George Thenthis M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 8-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE AUG-27 1949
24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER
24D. LOCATION (City, town, or county) (State) 4430 BELAIR RD MD ADDRESS

DATE RECEIVED AUG 29 1949
LOCAL REGISTRAR'S SIGNATURE Tuttington Williams, M.D.
25. FUNERAL DIRECTOR Duffiel Bro 1800 E LOMBARD ST

VS 150

109a

G776,22 ✓ G776,22

BALTIMORE CITY HEALTH DEPARTMENT 1343

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary E. Knox

2. DATE OF DEATH August 25, 1944

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1710 Druid Hill Avenue

c. Length of stay in Baltimore 20 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-2
D. STREET ADDRESS (If rural, give location) 1710 Druid Hill Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	Negro	married	April 15, 1893	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Maryland	U.S.A.

13. FATHER'S NAME: Basil Harrison

14. MOTHER'S MAIDEN NAME: Maria Boone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		-

17. INFORMANT — ADDRESS: Mrs Jessie Mills, Mitchellville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

ANTECEDENT CAUSES

(B) Hypertension — Aug 2 '44

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Hypertrophy & Dilatation of Heart

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 2, 1944 *to* Aug 25, 1944 *that I last saw the deceased alive on* Aug 25, 1944 *and that death occurred at* 2.30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	1723 Druid Hill Ave	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 29, 1944	Family Lot	Mitchellville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
S 26 1944 VS 150	[signature]	Holland Funeral Home	1631 Druid Hill Ave.

95c

G77623

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6/0

Registered No. G77623

1. NAME OF DECEASED (Type or Print) Myers, Mr. Franklin H.

2. DATE OF DEATH 8-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home + Hospital
c. Length of stay in Baltimore 9 Years Months Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Westminster
D. STREET ADDRESS (If rural, give location) R.F.D. #4

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Aug 15, 1862
9. AGE (In years last birthday) 87 yrs
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Myers Jessee
14. MOTHER'S MAIDEN NAME Sullivan, Margaret

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO.

17. INFORMANT Shaffer, Mrs Harry G. ADDRESS RFD #4 Westminster

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I (A) Arteriosclerotic Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 25± yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) Benign Prostatic Hypertrophy — 25 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 8-26-49
19B. MAJOR FINDINGS OF OPERATION Hypertrophy of Prostate
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 17 1949 *to* August 26, 1949 *that I last saw the deceased alive on* August 26 1949, *and that death occurred at* 3:35 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Ronald L. Leaton M. D.
23B. ADDRESS Church Home + Hosp.
23C. DATE SIGNED 8-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE AUG 30 1949
24C. NAME OF CEMETERY OR CREMATORY KRIDERS CEMETERY
24D. LOCATION (City, town, or county) (State) NEAR WESTMINSTER MD

DATE RECEIVED BY LOCAL REGISTRAR AUG 27 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS John R. Byers Westminster Md.

VS 150

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c/o Bethune 3139 E. Balt St

177624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77624

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE ROBERT HALL

2. DATE OF DEATH: August 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2201 Frankford Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-34
D. STREET ADDRESS (If rural, give location): 2201 Frankford Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 9, 1890
9. AGE (In years last birthday): 59
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintainence Man
10B. KIND OF BUSINESS OR INDUSTRY: Glen L. Martin
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James P. Hall
14. MOTHER'S MAIDEN NAME: Florida N. Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 214-20-4122
17. INFORMANT: Mrs Bessie Hall
ADDRESS: 2201 Frankford Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Endocarditis' over period of years. only time attend died was about 8 years ago, never been in hospitals.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1941, 19__, *to* Aug 25, 1949 *that I last saw the deceased alive on* Aug. 25, 1949 *and that death occurred at* 1 PM. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Allen C. Bertram, M. D.
23B. ADDRESS: 3139 E. Balt St.
23C. DATE SIGNED: 8-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/29/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, Md
25. FUNERAL DIRECTOR: William Cook, Inc.
ADDRESS: 1217 St. Paul St.

VS 150

92D

G77625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

470 1 Registered No. G77625

RTH NO.

1. NAME OF DECEASED (Type or Print): Annie Blanche Griffith

2. DATE OF DEATH: 8/24/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 25-4

3. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 430 Annabel Ave

D. STREET ADDRESS (If rural, give location): 430 Annabel Ave

Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: Female
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 6/24/1880
9. AGE (In years last birthday): 69
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James A. Chaney

14. MOTHER'S MAIDEN NAME: Eliza Watts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Allen Emge ADDRESS: 3705 5th St. Brooklyn

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH: 5 Years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——— 19 ——, *to* on Aug. 24 1949 *that I last saw the deceased alive on* Aug. 24, 1949, *and that death occurred at* 1307 m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Neubauer M. D.
23B. ADDRESS: 936 Patapsco Ave.
23C. DATE SIGNED: Aug. 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/27/49
24C. NAME OF CEMETERY OR CREMATORY: Glen Haven
24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 27 1949
REGISTRAR'S SIGNATURE: Huntington for Nathanson, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 150

944

BIRTH NO. 677626

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 9 76.° Registered No. 027626

1. NAME OF DECEASED (Type or Print): William Edward White — 2. DATE OF DEATH: August 25, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-7
d. STREET ADDRESS (If rural, give location): 525 W. 25th St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Widower	Feb. 17, 1885	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffer, retired	Automobile	England	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
No	216-01-8577	William H. White, 302 Woodlawn Road

MEDICAL CERTIFICATION

16. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bullet wound of Abdomen
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY☒ OR CONTRIBUTING☐ CAUSE OF DEATH.	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	525 W. 25th St.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
August 25, 1949 ? m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Firearms

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23a. SIGNATURE: Paul L. Ryan, M.D. — 23b. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ — 23c. DATE SIGNED: August 26, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/29/49	Western	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
AUG 27 1949	Huntington Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 151

164 c

77627 Dr Murgatroyd 401 E 25th St G77627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 241

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SAMUEL R. BUTTS

2. DATE OF DEATH: Aug. 25, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 712 East 23rd St.

b. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 712 East 23rd Street

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar. 31, 1887
9. AGE (In years last birthday): 62
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baggage Master
10B. KIND OF BUSINESS OR INDUSTRY: B.& O. R.R.

11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel G. Butts
14. MOTHER'S MAIDEN NAME: Alice Rankins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Ella N. Butts
ADDRESS: 712 East 23rd St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Cardiac Dilitation — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
(B) Chronic Bronchitis and Emphysema — unknown
DUE TO
(C) Bronchial Asthma — unknown

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 6th. 1949 *to* August 25th. 1949, *that I last saw the deceased alive on* August 25, 1949. *and that death occurred at* 9:55 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. W. Murgatroyd M. D.
23B. ADDRESS: 401 E. 25th. St. Balto. 18, Md.
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/29/49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Memorial Park
24D. LOCATION (City, town, or county) (State): Baltimore County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William Cook, Inc., 1217 St. Paul St.
ADDRESS

VS 150

106B

77628

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

151 Registered No. 677628

1. NAME OF DECEASED (Type or Print): HARRIETT (HATTIE) GITTINGS

2. DATE OF DEATH: Aug. 26, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3025 Widnson. Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1781 Montpelier St.

9-7

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow		About 80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Unknown	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Papers in her possession	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of An Stomach

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 22, 1949, to Aug 26, 1949, *that I last saw the deceased alive on* Aug 20, 1949, *and that death occurred at* 6:10 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. H. Patterman M. D.	2324 Reisterstown Rd	8/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/27/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 27 1949	Huntington Williams, M.D.	William Cook, Inc., 1217 St. Paul St.	

VS 150

46 B

G77629

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-0.0 G77629 Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE J. RICKER

2. DATE OF DEATH: Aug. 26th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4705 Grindon Ave.
C. Length of stay in Baltimore: 72 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 27-2
D. STREET ADDRESS (If rural, give location): 4705 Grindon Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widowed	Dec. 5, 1863	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): butcher (RET.)
10B. KIND OF BUSINESS OR INDUSTRY: RETAIL meat - SELF
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George J. Ricker
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Harry C. Ricker, ADDRESS: 1638 Round Hill Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemiplegia, left. — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Hypertensive-arteriosclerotic heart disease — 30 yr.

DUE TO

(C) Prostatic hypertrophy — 30 yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 23, 1949, *to* Aug 26, 1949, *that I last saw the deceased alive on* Aug 25, 1949, *and that death occurred at* 8:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Adam Slevin M. D.
23B. ADDRESS: 6232 Belair Rd.
23C. DATE SIGNED: Aug. 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	Aug. 29, 1949	Oak Lawn Cemetery	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Loane's Funeral Home — ADDRESS: 7401 Belair Rd.

VS 150

937

G77630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77630

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Schuster, Mr. John

2. DATE OF DEATH 8-26-49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home + Hospital

c. Length of stay in Baltimore 65 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Md. b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Parkville
d. STREET ADDRESS (If rural, give location) 7818 Oak Ave

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Dec. 26, 1872 | 9. AGE (In years last birthday) 76 years | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER (Ret.) | 10B. KIND OF BUSINESS OR INDUSTRY SELF

11. BIRTHPLACE (State or foreign country) Germany | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Schuster, Mr. Matthew

14. MOTHER'S MAIDEN NAME Anna Grous

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Lawerance, Mr. Minton ADDRESS 7850 Belair Rd Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.

DUE TO

(B) Hypertensive, Arteriosclerotic Cardiovascular Disease — 2 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION August 24 1949 | 19B. MAJOR FINDINGS OF OPERATION (Chronic Duodenal) Ulcer | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 24 1949 to Aug 26, 1949 that I last saw the deceased alive on Aug. 26 1949 and that death occurred at 9: A1 m., from the causes and on the date stated above.

23A. SIGNATURE Ronald L Keaton M.D. | 23B. ADDRESS Church Home + Hosp. | 23C. DATE SIGNED Aug 29 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) burial | 24B. DATE Aug. 29, 1949 | 24C. NAME OF CEMETERY OR CREMATORY St. Johns Lutheran Cemetery | 24D. LOCATION (City, town, or county) (State) Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 27 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D | 25. FUNERAL DIRECTOR Lawrence Funeral Home | ADDRESS 7401 Belair Rd.

VS 150

1173

G77631

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

605 Registered No. G77631

1. NAME OF DECEASED (Type or Print) ANTON ESPOSITO

2. DATE OF DEATH August 26, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital
Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-1

d. STREET ADDRESS (If rural, give location) 4328 Glenmore Ave.

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower

8. DATE OF BIRTH 8/4/60

9. AGE (In years last birthday) 89 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Balto, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT ADDRESS Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Nephrosclerosis with uremia — Interval between onset and death: Unknown

DUE TO

(B) Benign hypertrophy of prostate — Unknown

DUE TO

(C) Cystitis, chronic, severe — Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE? (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 25 1949, *to* Aug. 26, 1949, *that I last saw the deceased alive on* Aug. 26, 1949, *and that death occurred at* 5:55A m., *from the causes and on the date stated above.*

23A. SIGNATURE Raymond Green, Sr. Surgeon USPHS M. D.

23B. ADDRESS US Marine Hospital, Balto, Md.

23C. DATE SIGNED 8/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial

24B. DATE Aug. 29, 1949

24C. NAME OF CEMETERY OR CREMATORY Lorraine Park

24D. LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 27 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR Lassahn Funeral Home ADDRESS 7401 Belair Rd.

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131a

G77632

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Vol. 1 G77632 Registered No.

1. NAME OF DECEASED (Type or Print) Edward Theodore Nicols

2. DATE OF DEATH Aug-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1812 St Paul

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at home

C. Length of stay in Baltimore 23 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-5
D. STREET ADDRESS (If rural, give location) 1812 St Paul St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Oct 20 1861	87 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	retired.	Maryland	U.S.

13. FATHER'S NAME Thos. C. Nicols

14. MOTHER'S MAIDEN NAME Margaret P. Wroth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	none	Ewald Nicols - wife	1812 St Paul

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 wks.
DUE TO
(B) coronary sclerosis — —
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Bronchial asthma — many yrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
No —	—	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
— No	—	

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 1, 1949 *to* Aug 26, 1949 *that I last saw the deceased alive on* Aug 22, 1949 *and that death occurred at* 7A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William L Penner M. D.	11 W. 29th St	8/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug-29-49	Springhill	Easton Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 27 1949	Huntington Williams, MD	Stewart Hommo	Balto

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77633

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 77633

1. NAME OF DECEASED (Type or Print): John S. Yellott

2. DATE OF DEATH: Aug. 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

C. Length of stay in Baltimore: – Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Reisterstown
D. STREET ADDRESS (If rural, give location): –

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: April 27, 1889
9. AGE (In years last birthday): 60
If under 1 year: Months: Days
If under 24 hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Daniel Yellott
14. MOTHER'S MAIDEN NAME: Mary Morss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): –
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: –

17. INFORMANT: Fitahugh Yellott
ADDRESS: Westminster

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) bilateral Bronchiectasis, chronic malnutrition

DUE TO

(B) Chronic Bronchitis

DUE TO

(C) Emphysema

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: yrs.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-4- 1949 *to* 8-27- 1949, *that I last saw the deceased alive on* 8-26- 1949, *and that death occurred at* 7:15A m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Fred Hawkins Jr. M. D.
23B. ADDRESS: Franklin Square Hosp.
23C. DATE SIGNED: 8/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-29-49
24C. NAME OF CEMETERY OR CREMATORY: All Saints Cem.
24D. LOCATION (City, town, or county) (State): Reisterstown, Md.

DATE RECEIVED BY LOCAL REGISTRAR: 8-27-49
REGISTRAR'S SIGNATURE: Huntington Williams, Mp
25. FUNERAL DIRECTOR: J.F.Eline & Sons-Reisterstown, Md.
ADDRESS

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G77634 ✓ 1 G77634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **George W. Tugwell, Sr.**

2. DATE OF DEATH **Aug. 26/49**

3. PLACE OF DEATH: a. Baltimore City, Maryland **Baltimore, Md.**

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **118 S. Tremont Rd.**

c. Length of stay in Baltimore **69 yrs.** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** 28-4
D. STREET ADDRESS (If rural, give location) **118 S. Tremont Road**

5. SEX **Male** | 6. COLOR OR RACE **White** | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Widowed** | 8. DATE OF BIRTH **Nov. 29, 1878** | 9. AGE (In years last birthday) **70** | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired** | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Penna.** | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Lewellyn Tugwell**

14. MOTHER'S MAIDEN NAME **Ellen Wilson**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT **Mrs. LouisSpittel, 118 S. Tremont Rd** ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Coronary Thrombosis** — Interval between onset and death: **Immediate**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Coronary Artery Disease** — **3 yrs.**

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. **Carcinoma of Prostate** — **2 yrs.**

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1947, *to* Aug ____, 1949, *that I last saw the deceased alive on* 8/2 ____, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE **Lawrence M. Lenz** M. D. | 23B. ADDRESS **11 E. Chase St.** | 23C. DATE SIGNED **8/27/49**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** | 24B. DATE **Aug. 29/49** | 24C. NAME OF CEMETERY OR CREMATORY **Woodlawn Cemetery** | 24D. LOCATION (City, town, or county) (State) **Woodlawn, Md.**

DATE RECEIVED BY LOCAL REGISTRAR **AUG 27 1949** | REGISTRAR'S SIGNATURE **Huntington Williams, M.D.** | 25. FUNERAL DIRECTOR **Harry A. Nitz** | ADDRESS **4161 Edmondson Ave.**

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CERTIFICATE CORRECTED 8-30-49 ✓

G77635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77635

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print) HAROLD JOHN H. EASTERDAY — N-803.Y

2. DATE OF DEATH August 26th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital
C. Length of stay in Baltimore 9 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) (Baltimore) -- 20 - Rural Middle River
D. STREET ADDRESS (If rural, give location) C 1 - Cypress Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Jan. 27, ~~1910~~ 1909	40 39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist
10B. KIND OF BUSINESS OR INDUSTRY Glenn Martin Aircraft
11. BIRTHPLACE (State or foreign country) Boonsboro, ~~Hagerstown~~, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Edward F. Easterday
14. MOTHER'S MAIDEN NAME Mollie V. Masters
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 214-09-2865
17. INFORMANT Mrs. Mary Louise Easterday -- wife ADDRESS C 1 -Cypress Drive, Balto. Co. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Crushed Skull
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Industrial
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Glen L. Martins -- Middle River, Balto. Co, Md.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 27, '49 11:30p. m.
21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Struck by falling boom

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L Boyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 28 Aug x9

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/24/49	Mary Rose Hill Cem.	Hagerstown Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 27 1949
REGISTRAR'S SIGNATURE Cumberton Williams, M.D.
25. FUNERAL DIRECTOR F.K. Hoffman ADDRESS Hagerstown 176 Md

VS 151

G77636

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170

G77636

Registered No.

1. NAME OF DECEASED (Type or Print) Marguerite V. Lorah

2. DATE OF DEATH 8-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland W. Balto. Gen. Hos.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto. Gen. Hos.

C. Length of stay in Baltimore 3 Mo. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pa.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hazleton
D. STREET ADDRESS (If rural, give location) 615 W. 6th. St.

5. SEX Female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH Nov. 10, 1900 | 9. AGE (In years last birthday) 48 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Pa. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Perry

14. MOTHER'S MAIDEN NAME Mary Vehman Brill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Miss E. Irene Perry ADDRESS W. Balto. Gen. Hos.

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of left breast — INTERVAL BETWEEN ONSET AND DEATH: Sept. '48 to Aug. '49

DUE TO

(B) & metastasis to lungs,

DUE TO

(C) glands, liver & spleen

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-23, 1949 *to* 8-26, 1949 *that I last saw the deceased alive on* 8-26, 1949, *and that death occurred at* 12:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE W. W. Biderman M.D. M. D. | 23B. ADDRESS W B & H. | 23C. DATE SIGNED 8-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/29/49 | 24C. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery | 24D. LOCATION (City, town, or county) (State) W. Hazleton, Pa.

DATE RECEIVED BY LOCAL REGISTRAR AUG 27 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR John O. Mitchell Sons | ADDRESS 1900 Eutaw Place

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G77637

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77637

Registered No.

1. NAME OF DECEASED (Type or Print) LELIA T. BUFFINGTON

2. DATE OF DEATH 8-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP.

c. Length of stay in Baltimore 5-2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY B

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 18

D. STREET ADDRESS (If rural, give location) 207 ST. MARKINS RD. 12-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	M	9/21/67	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE		MD.	USA

13. FATHER'S NAME ROBERT TALBOT

14. MOTHER'S MAIDEN NAME MATILDA JARMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Left cerebral hemorrhage, recent — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Cerebral arteriosclerosis

DUE TO

(C) Cerebromalacia - rt-old.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Ruptured pyloric ulcer

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-22, 1949, *to* 8-26, 1949, *that I last saw the deceased alive on* 8-26, 1949, *and that death occurred at* 5:32 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Green, M. D.	815 Union Memorial Hosp.	8-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug. 29, 1949	Greenmount Cemy	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 27 1949	Lennington Williams, M.D.	John C. Mitchell & Sons	1900 Eutaw Place

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G77638

BIRTH NO

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Hyp 1

G77638 Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM C. HARRISON

2. DATE OF DEATH: Aug. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 213 Goodale Rd.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-6
D. STREET ADDRESS (If rural, give location): 2948 Wyman Parkway

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept. 18, 1884.
9. AGE (In years last birthday): 64 yrs.
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Willias Harrison
14. MOTHER'S MAIDEN NAME: Hattie Walston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. H. Alfred Stalfort. - ADDRESS: 213 Goodale Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 47 *to* 8/25/49, *that I last saw the deceased alive on* 8/23/49, *and that death occurred at* 9:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John R Davis M. D.
23B. ADDRESS: 211 Med Arts.
23C. DATE SIGNED: 8/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug.29,1949
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Maus.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 27 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

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G77639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59 2 X

Registered No. G77639

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CORA LEE V. STEVENS

2. DATE OF DEATH Aug. 25, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2120 N. Fulton Ave.

b. Length of stay in Baltimore 20 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-4
D. STREET ADDRESS (If rural, give location) 2120 N. Fulton Ave.

5. SEX female

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Sept. 27, 1893

9. AGE (In years last birthday) 55 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) N. H.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Alonzo G. Dudley

14. MOTHER'S MAIDEN NAME - McCabe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. no

17. INFORMANT Mr. G. Judd Stevens ADDRESS 2120 N. Fulton Ave.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrage — INTERVAL BETWEEN ONSET AND DEATH 8/23/49

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Ch. Myocarditis — 1937

DUE TO

(C) Chr. Interstitial Nephritis — 1937

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 15 *1947 to* Aug 25 *1949 that I last saw the deceased alive on* Aug 24 *1949, and that death occurred at* 2 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE Paul Brown M. D.

23B. ADDRESS 1663 W. North Ave.

23C. DATE SIGNED 8/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/29/49

24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 27 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

VS 150

131a

77640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

Registered No. 77640

RTH NO.

1. NAME OF DECEASED (Type or Print): MINNIE HESS Marcus

2. DATE OF DEATH: August 25, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Esplanade Apts. Eutaw Place & Brooks Lane

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-1
D. STREET ADDRESS (If rural, give location): Esplanade Apt. 8D; Eutaw Pl.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 11, 1863
9. AGE (In years last birthday) / If Under 1 Year: Months Days / If Under 24 Hours: Hours Min.: 86 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Emanuel Hess

14. MOTHER'S MAIDEN NAME: Rebecca Rosenstock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No, yes or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Dr. E. M. Bernheim ADDRESS: 2424 Eutaw Place

CAUSE OF DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

DUE TO

(B) Paroxysmal tachycardia — 2 hrs

DUE TO

(C) Hypertensive CVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 17, 1949 *to* August 25, 1949, *that I last saw the deceased alive on* August 25 1949, *and that death occurred at* 11:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. Donald Landon M. D.
23B. ADDRESS: Riviera Apt 4H Balto.
23C. DATE SIGNED: 8-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/29/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

93D

G77641

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

005

Registered No. G77641

1. NAME OF DECEASED (Type or Print): Sister Mary Anselm Keenan, O. S. F.

2. DATE OF DEATH: August 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3725 Ellerslie Avenue

C. Length of stay in Baltimore: 1 year (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 9-1
D. STREET ADDRESS (If rural, give location): 3725 Ellerslie Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	White	Single	May 28, 1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher	ORPHANAGE	Rutland, Vermont	U.S.

13. FATHER'S NAME: John Keenan

14. MOTHER'S MAIDEN NAME: Nancy Dowling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No				

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO Tuberculosis, glandular, cervical	
	Tuberculosis, skin, cervical	2 yrs.
ANTECEDENT CAUSES	(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) Diverticulosis with possible diverticulitis. Hepatitis, transfusion reactio	2 wks.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May, 1949, *to* Aug. 26, 1949, *that I last saw the deceased alive on* 26 Aug., 1949, *and that death occurred at* 1030 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. M. K. Kamma, D. M. D.	501 Sheridan Ave.	28 Aug. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 29/49	St Elizabeth's Home	3725 Ellerslie Ave Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 27 1949	Huntington Williams, M.D.	Henry H. Jenkins & Sons Co	1905 York Rd.

VS 150

19

G77642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-0 1

G77642

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JULIA EMMA BENTLEY

2. DATE OF DEATH AUG. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1359 GORSUCH AVE

C. Length of stay in Baltimore 56 YRS. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO. 9-5
D. STREET ADDRESS (If rural, give location) 1359 GORSUCH AVE

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED

8. DATE OF BIRTH OCT. 17, 1871

9. AGE (In years last birthday) 77 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME JOHN T. WILSON

14. MOTHER'S MAIDEN NAME SARAH C. PATTERSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT SARAH M. CAMPBELL ADDRESS 1359 GORSUCH

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH —

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardio-Vascular disease.

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Broncho-Pneumonia. 2 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/23, 1949, *to* 8/25, 1949, *that I last saw the deceased alive on* 8/25, 1949, *and that death occurred at* 7:P m., *from the causes and on the date stated above.*

23A. SIGNATURE H B Lewis M. D.

23B. ADDRESS 3400 Erdman Ave

23C. DATE SIGNED 8/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE AUG. 29, '49

24C. NAME OF CEMETERY OR CREMATORY MT. VIEW

24D. LOCATION (City, town, or county) (State) HOWARD Co. MD.

DATE RECEIVED BY LOCAL REGISTRAR AUG 27 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR H. W. JENKINS & SONS Co.

ADDRESS 4905 YORK RD.

VS 150

931

BIRTH NO. 77643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 77643

1. NAME OF DECEASED (Type or Print): PHILLIP BENJAMIN FREDERICK

2. DATE OF DEATH: AUG. 26, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 617 RESERVOIR ST.

b. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 13-2
D. STREET ADDRESS (If rural, give location): 617 RESERVOIR ST.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: MAR. 5, 1878
9. AGE (In years last birthday): 71
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MANAGER
10B. KIND OF BUSINESS OR INDUSTRY: ICE CO.
11. BIRTHPLACE (State or foreign country): BALTO., MD.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: BENJAMIN F. FREDERICK
14. MOTHER'S MAIDEN NAME: MARTHA JACKSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS. R. K. FREDERICK ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertrophic Biliary Cirhosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO
(B) Generalized Arteriosclerotic — 3 years
DUE TO
Cardio Vascular disease
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 49 *to* August 26, 1949, *that I last saw the deceased alive on* Aug 26 1949, *and that death occurred at* 9.55 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Samuel L. Brown, M. D.
23B. ADDRESS: 1938 Eutaw Place
23C. DATE SIGNED: 28 Aug 49.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 8-29-1949
24C. NAME OF CEMETERY OR CREMATORY: LOUDON PARK
24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. W. JENKINS & SONS CO.
ADDRESS: 4905 YORK RD.

VS 150

124B

77644

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1

G77644

Registered No.

1. NAME OF DECEASED (Type or Print) FREDERICK CARL KERR

2. DATE OF DEATH AUG. 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 522 RADNOR AVE

C. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN BALTO (If outside corporate limits, write RURAL and give township) 27-10
D. STREET ADDRESS (If rural, give location) 522 RADNOR AVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	MARRIED	JUNE 24, 1899	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME JOHN EDWARD KERR

14. MOTHER'S MAIDEN NAME BETTIE FREDERICK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT MRS. MARIE E. KERR ADDRESS 522 RADNOR AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — 1 hr.

DUE TO

(B) Arteriosclerosis of Coronary Vessels — 2 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 23, 1949 *to* Aug. 25, 1949 *that I last saw the deceased alive on* Aug. 25, 1949 *and that death occurred at* 10:15 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE Lloyd E. Taylor M. D.

23B. ADDRESS 3902 Greenmount Ave

23C. DATE SIGNED Aug. 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE AUG. 29 '49

24C. NAME OF CEMETERY OR CREMATORY PARKWOOD

24D. LOCATION (City, town, or county) (State) PARKVILLE MD.

DATE RECEIVED BY LOCAL REGISTRAR AUG 27 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR H. W. JENKINS & SONS CO.

ADDRESS 4905 YORK RD.

VS 150

94a

G77645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

605

Registered No. G77645

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Hannah E. Wright

2. DATE OF DEATH Aug. 26, 1949

3. PLACE OF DEATH: Baltimore City, Maryland 5418 Hilburn Ave.

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

b. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-8
D. STREET ADDRESS (If rural, give location) 125 S. Highland Ave.

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W
8. DATE OF BIRTH Oct. 2, 1869
9. AGE (In years last birthday) 79
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Hasenei

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT David Wright ADDRESS 125 S. Highland Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH 10 days
DUE TO Pulmonary Edema
(B) Chr. Asthma & Arteriosclerosis
DUE TO Chr. Cystitis
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 6, 1949 to Aug 26, 1949, that I last saw the deceased alive on Aug 26, 1949, and that death occurred at 9 a. m., from the causes and on the date stated above.

23A. SIGNATURE Wm G. Geyer M. D.
23B. ADDRESS 156 N. Milton Ave.
23C. DATE SIGNED 8/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/29/49
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn
24D. LOCATION (City, town, or county) (State) 7225 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR AUG 27 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Clarence F. Hoffmann ADDRESS 1639 Broadway.

VS 150

93c

77646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G77646

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth Hofferbert

2. DATE OF DEATH Aug. 26, 1949

3. PLACE OF DEATH: (a) Baltimore City, Maryland (b) FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3618 Hamilton Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-L
D. STREET ADDRESS (If rural, give location) 1733 N. Washington St.

e. Length of stay in Baltimore — Yrs. Mon. Days

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W

8. DATE OF BIRTH July 28, 1860 | 9. AGE (In years last birthday) 89 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Casper Lingelbach

14. MOTHER'S MAIDEN NAME Anna Broening

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT L.T. Neumann | ADDRESS 2500 Halcyon Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) acute Paroxysmal Dyspnea — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(B) arteriosclerotic Heart Disease — 5 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — | 19B. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 26, 1949, *to* Aug 26, 1949, *that I last saw the deceased alive on* Aug 26, 1949, *and that death occurred at* 10 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE George Dawson M. D. | 23B. ADDRESS 4808 Harford Rd. | 23C. DATE SIGNED 8/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8/29/49 | 24C. NAME OF CEMETERY OR CREMATORY Baltimore | 24D. LOCATION (City, town, or county) (State) North Ave & Rose St.

DATE RECEIVED BY LOCAL REGISTRAR AUG 27 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Clarence F. Hoffmann | ADDRESS 1639 Broadway

VS 150

93

HANNA-G-RAMSAY

G77647

BALTIMORE CITY HEALTH DEPARTMENT 331

CERTIFICATE OF DEATH

G77647 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (HANNA) Hannah G. Ramsay

2. DATE OF DEATH 8/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-6
D. STREET ADDRESS (If rural, give location) 2735 Maryland Ave.

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 3/31/1867
9. AGE (In years last birthday) 82 If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Nathan Pyle
14. MOTHER'S MAIDEN NAME Margaret Carter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT ADDRESS

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH

DUE TO RIGHT & LEFT SIDED HEMIPLEGIA

(B) BILATERAL CONFLUENT PNEUMONIA

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/21, 1949 *to* 8/27, 1949 *that I last saw the deceased alive on* 8/24, 1949, *and that death occurred at* 9:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE John H. Adam M. D.
23B. ADDRESS St. Agnes Hosp.
23C. DATE SIGNED 8/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 28 49
24C. NAME OF CEMETERY OR CREMATORY Slate Ridge Cem.
24D. LOCATION (City, town, or county) (State) Dobbs - Pa

DATE RECEIVED BY LOCAL REGISTRAR AUG 27 1949
REGISTRAR'S SIGNATURE Emmitt Gorton Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS H. B. Kippert & Son - 1300 Eutaw St.

VS 150

108 7

77648

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77648

Registered No.

1. NAME OF DECEASED (Type or Print) James W. Hill

2. DATE OF DEATH Aug. 23, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland St. Agnes

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-3
D. STREET ADDRESS (If rural, give location) 207 E. Jefferson St.

5. SEX M

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 1-7-1893

AGE (In years last birthday) 56 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John

14. MOTHER'S MAIDEN NAME Mary Elliott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or compilication which caused death.)

(A) DEGENERATIVE CARDIO-VASCULAR

DUE TO DISEASE C ACUTE

(B) CARDIAC FAILURE

DUE TO

(C) GENERALIZED ANASARCA

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/19, 1949, *to* 8/23, 1949, *that I last saw the deceased alive on* 8/21, 1949, *and that death occurred at* 5:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE John W. Shaw M. D.

23B. ADDRESS St. Agnes Hosp.

23C. DATE SIGNED 8/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/27/49

24C. NAME OF CEMETERY OR CREMATORY Cathedral

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY REGISTRAR AUG 27 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR M. Dalrymple Sons

ADDRESS 1827 W. North

VS 150

931

G77649
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163 Registered No. G77649

1. NAME OF DECEASED (Type or Print) JOHN JOSEPH BLAIR

2. DATE OF DEATH August 25, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Texas
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Port Arthur
D. STREET ADDRESS (If rural, give location) 1412 Houston Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
M	W	Div.	8/16/01	48				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pumpman	Seafarer	Balto, Md.	USA

13. FATHER'S NAME Frederick Blair

14. MOTHER'S MAIDEN NAME Mary Ellen Gubb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown

16. SOCIAL SECURITY NO. 456-12-3221

17. INFORMANT Records- US Marine Hospital, Balto, Md. ADDRESS

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of right lung with general carcinomatosis of peritoneal cavity	Unknown
DUE TO	(B)	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Aug. 15, 1949, *to* Aug. 25, 1949, *that I last saw the deceased alive on* Aug. 25, 1949, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson, Medical Director, M. D.	US Marine Hospital, Balto. Md.	8/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Aug. 27-49	Mt. Carmel	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 27 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John F. Connelly ADDRESS 418 Eastern Ave Balto 21 Md.

47D

VS 150

7640914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54.6

G77650

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) — Wayne Pavlic

2. DATE OF DEATH — AUG 26 1949

3. PLACE OF DEATH: Baltimore City, Maryland — Halstead 3

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore — Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — Pa.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — McDonald
D. STREET ADDRESS (If rural, give location) — 209 E. Lincoln Ave.

5. SEX — male
6. COLOR OR RACE — white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) — S.
8. DATE OF BIRTH — 8-1-48
9. AGE (In years last birthday) — If Under 1 Year: Months 11, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — Child
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) — Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME — Andrew Pavlic

14. MOTHER'S MAIDEN NAME — Stella Baron

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS — JOHNS HOPKINS HOSPITAL

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Lt Nephrectomy & ureters.
DUE TO subarachnoid exhaustion
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Lt Communicating

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — E-13-49
19B. MAJOR FINDINGS OF OPERATION — Hydrocephalus, Lt. communicating
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-6- 1949 *to* 8-26-, 1949, *that I last saw the deceased alive on* 8-26-, 1949, *and that death occurred at* 1030 *m., from the causes and on the date stated above.*

23A. SIGNATURE — A. S. McGeehan M. D.
23B. ADDRESS — JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED — E-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify) — Removal
24B. DATE — Aug 29/49
24C. NAME OF CEMETERY OR CREMATORY — Robinson Run Cem
24D. LOCATION (City, town, or county) (State) — McDonald Pa

DATE RECEIVED BY LOCAL REGISTRAR — AUG 27 1949
REGISTRAR'S SIGNATURE — Livingston Williams, M.D.
25. FUNERAL DIRECTOR — Ulmk Funeral Home
ADDRESS — 2008 Orleans

VS 150

1570

G77651 CERTIFICATE CORRECTED 8-31-49 ✓ G77651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CERTIFICATE CORRECTED 12-9-49 GERTRUDE NETHERLAND

2. DATE OF DEATH 12 Midnight August 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) 11-1
D. STREET ADDRESS (If rural, give location) 216 E. Preston St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Married	Dec. 9, 1919	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Morgantown W Va	

13. FATHER'S NAME Thomas C. Herron

14. MOTHER'S MAIDEN NAME Blanche Sample

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		J. T. Anderson	Beaver, Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Ballet wounds of chest + abdomen

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	216 E. Preston St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21F. HOW DID INJURY Ooccur?
August 27, 1949 p.m.		Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy ✓ Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
Earl L. Royer M.D.		28 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/30/49	Oak Grove Cem. Sewickley	Beaver Co Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 28 1949	Thurlington Williams, M.D.	Wm. J. Dyckman & Sons	North Ave

VS 151

166

G77652 CERTIFICATE CORRECTED 8-31-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No. G77652

CERTIFICATE CORRECTED 12-5-[illegible]

1. NAME OF DECEASED (Type or Print) ROBERT NETHERLAND

2. DATE OF DEATH 12:35 a.m. August 28th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-1
D. STREET ADDRESS (If rural, give location) 216 E. Preston Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	Aug. 3, 1908	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER	BLDG. CONSTRUCTION	Cohoes, New York	

13. FATHER'S NAME Michael Netherland

14. MOTHER'S MAIDEN NAME Martha Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	184-18-0211	J. T. Anderson	Son Beaver Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bullet wound of Brain
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	216 E. Preston St.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 27, 1949 ? p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Earl L. Bruce, M.D.	☐ / ☐ / ☐	8-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/30/49	Oak Grove Cemt.	Beaver Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 28 1949	Huntington Williams, M.D.	Wm. J. Sisemore & Sons	North Ave

VS 151 Sewickley 164 c

G77653

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 77653

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EMIL MACH

2. DATE OF DEATH: August 25, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pine Crest Con. Home

Length of stay in Baltimore: 70 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-1
D. STREET ADDRESS (If rural, give location): 1113 E. Forrest Street

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 9/10/1879
9. AGE (In years last birthday): 69 71 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Phillips Bottleing Co.
11. BIRTHPLACE (State or foreign country): Czechoslovakia
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-05-8345
17. INFORMANT: John J. Mach, ADDRESS: 2829 E. Chase St.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO

(B) Hypertensive Cardio Vascular Disease — years

DUE TO

(C) Generalized arteriosclerosis — years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from February 1st, 1949, to August 25, 1949, that I last saw the deceased alive on August 25, 1949, and that death occurred at 7:30 P m., from the causes and on the date stated above.

23A. SIGNATURE: Melvin H. Bruley M.D.
23B. ADDRESS: 2130 W. Fayette
23C. DATE SIGNED: 8/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/29/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town or county) (State): 4450 Belair Rd. Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR AND ADDRESS: 2601-5-5 E. Madison St. Schimunek Funeral Home, Inc.

93D

G77659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 982.0 G77659

Registered No. 3592

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LOUIS BLUMBERG

N-503.2

2. DATE OF DEATH August 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hospital

c. Length of stay in Baltimore 60 Yrs. Mos. Days.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-1
D. STREET ADDRESS (If rural, give location) 903 Lakedrive Apartments

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Married	11-5-1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman

10B. KIND OF BUSINESS OR INDUSTRY Department Store

11. BIRTHPLACE (State or foreign country) Lith

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Mose

14. MOTHER'S MAIDEN NAME Frieda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Sara Blumberg ADDRESS Lake Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of Skull
DUE TO
(B) Intracranial Hemorrhage

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) areaway

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) areaway between the Lakedrive Apartments

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 26, 1949 6a.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? undetermined (Fell or jumped from win dow)

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from* (Autopsy, Inspection or Inquiry) *the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☒.

23A. SIGNATURE Emil L. Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED August 26, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-28-49	Oheb Shalome	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 28 1949

REGISTRAR'S SIGNATURE Cunningham Williams, M.D.

25. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

186a

VS 151

G77655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77655

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) JACOB HARER

2. DATE OF DEATH 8-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 103 No Milton Ave

C. Length of stay in Baltimore 36 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-2
D. STREET ADDRESS (Number, give location) 103 No Milton Ave

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH

9. AGE (In years last birthday) 60
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor

10B. KIND OF BUSINESS OR INDUSTRY self

11. BIRTHPLACE (State or foreign country) Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Morris

14. MOTHER'S MAIDEN NAME Fruma

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Bessie Darer 103 No Milton ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Lung

DUE TO

(B) with metastasis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

19A. DATE OF OPERATION 1947

19B. MAJOR FINDINGS OF OPERATION Ca of the right lung

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1947 *to* Aug. 26 1949 *that I last saw the deceased alive on* Aug 26, 1949, *and that death occurred at* 4 p m., *from the causes and on the date stated above.*

23A. SIGNATURE Saul Sakulin M. D.

23B. ADDRESS 2128 W. North Ave

23C. DATE SIGNED 8/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8-28-49

24C. NAME OF CEMETERY OR CREMATORY Hebrew Young Men

24D. LOCATION (City, town, or county) Balto (State) Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 28 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Lewis Inc

ADDRESS 2100 Eutaw Pl

VS 150

47D

077656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

41 077656

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Matt Johnson

2. DATE OF DEATH 8/26/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 23-1
D. STREET ADDRESS (If rural, give location) 1030 Sharp Street

5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH 3/12/24 | 9. AGE (In years last birthday) 25 27 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Mayesville S.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Gredge Barno

14. MOTHER'S MAIDEN NAME Bessie Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diffuse Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO

(B) Rupture Duodenal Ulcer — 24 hrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 8/26/49

19B. MAJOR FINDINGS OF OPERATION Peritonitis, Ruptured ulcer.

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/26/49, 19__, *to* 8/26/49, 19__, *that I last saw the deceased alive on* 8/26/49 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE William B. Cooper Jr M. D.

23B. ADDRESS 1213 Light Street

23C. DATE SIGNED 8/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE Aug 28, 1949

24C. NAME OF CEMETERY OR CREMATORY Washington, D.C.

24D. LOCATION (City, town, or county) (State) District of Columbia

DATE RECEIVED BY LOCAL REGISTRAR 8-28-1949

REGISTRAR'S SIGNATURE Ernestine Williams, M.D.

25. FUNERAL DIRECTOR Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

VS 150

1178

077657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1 077657

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clarence E. Kroh

2. DATE OF DEATH 8/26/49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1339 Glyndon Ave

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-2

D. STREET ADDRESS (If rural, give location) 1339 Glyndon Ave

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 7/5/1904

9. AGE (In years last birthday) 45 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker

10B. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 243-14-4806

17. INFORMANT Mrs Stephen Henday ADDRESS 1339 Glyndon Ave

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO

(B) Coronary Thrombosis — 2 months

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 20 1949 *to* Aug 26, 1949, *that I last saw the deceased alive on* Aug 25, 1949, *and that death occurred at* 5:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Morris B. Schreiber, M. D.

23B. ADDRESS 54 S. Fulton Ave

23C. DATE SIGNED 8-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/29/49

24C. NAME OF CEMETERY OR CREMATORY Gunpowder Baptist Cem

24D. LOCATION (City, town, or county) (State) Middletown Balto. County Md.

DATE RECEIVED BY LOCAL REGISTRAR 8/28/1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Roth & B. M. Walter Pratt & Fleischhauer

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CERTIFICATE CORRECTED 9-1-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077658

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (ANTON) Anthony C. LITERSKI

2. DATE OF DEATH Aug 26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Md.

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3008 Pinewood Ave.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.

3b. Length of stay in Baltimore life Yrs. Mos. Days

4d. STREET ADDRESS (If rural, give location) 3008 Pinewood Ave 27-05

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Jan 29-1893 | 9. AGE (In years last birthday) 56 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commissary Clerk | 10B. KIND OF BUSINESS OR INDUSTRY City Hospital

11. BIRTHPLACE (State or foreign country) Balto. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Anton Literski

14. MOTHER'S MAIDEN NAME Rosalie Bzuzkowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes | (If yes, give war or dates of service) World War I | 16. SOCIAL SECURITY NO. 217-20-4540

17. INFORMANT Bertha Literski | ADDRESS 3008 Pinewood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — | 19B. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Aug 23, 1949, to Aug 25, 1949, that I last saw the deceased alive on Aug 23, 1949, and that death occurred at 10:30 a.m. from the causes and on the date stated above.

23A. SIGNATURE Melvin J. Jarnowski M. D. | 23B. ADDRESS 3911 Eastern Ave. | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug 29 49 | 24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus | 24D. LOCATION (City, town, or county) (State) Dundalk Ave Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR [illegible] | REGISTRAR [illegible] | 25. FUNERAL DIRECTOR Wm S. Zielkowski | ADDRESS 2007 Eastern Ave.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 19

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Godfrey Trippe

2. DATE OF DEATH August 27, 1949

3. PLACE OF DEATH: Baltimore City, Maryland U.S. Marine Hospital

(If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Virginia, B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Norfolk

D. STREET ADDRESS (If rural, give location) 309 Reeves Avenue

3. FULL NAME OF HOSPITAL OR INSTITUTION U.S. Marine Hospital

3. Length of stay in Baltimore 1 month, 20 days (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	Oct 12, 1903	45	10	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant Seaman	Seaman	North Carolina	U.S.A.

13. FATHER'S NAME Godfrey Trippe,

14. MOTHER'S MAIDEN NAME Mary T. Gill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown	---	Wife, Bessie Trippe,	same.

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Melanoma, malignant, right buttock	3½ yrs.
DUE TO		
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
4-16-49	Biopsy of axillary lymph node--tissue showed melanoma	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
---	--	--

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
--- m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	---

22. *I hereby certify that I attended the deceased from* July 7, 1949 *to* Aug 27, 1949, *that I last saw the deceased alive on* August 27 1949, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ray Brown Ray Brown, M. D. M. D.	Officer of the Day U.S. Marine Hospital, Balt., MD.	8-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 30 1949		Norfolk, Va.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
	Hunter for Williams, M.D.	Howard H Hudgins	2503 Edmondson Ave

WS 150

AUG 28 1949

53

7660

BIRTH NO. J-1- 102449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-20-1

077660 Registered No.

1. NAME OF DECEASED (Type or Print) George Schmeiser

2. DATE OF DEATH 8-24-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimor e City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore
(If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) NoHome- B. C. H. Infirmary 26-12

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Dec. ? 1864
9. AGE (In years last birthday) 84 ? (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Schmeiser
14. MOTHER'S MAIDEN NAME Hart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT B. C. H. Records, 4940 Eastern Ave. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Probable Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-29-49, 19__, *to* Aug. 24, 19 49 *that I last saw the deceased alive on* Aug. 24, 19 49 *and that death occurred at* 4.20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE P. S. Regan M. D.
23B. ADDRESS 4940 Eastern Ave.
23C. DATE SIGNED 8-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/30/49
24C. NAME OF CEMETERY OR CREMATORY Trinity
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR Wilhelm & Son
ADDRESS 1219 N Paca St

VS 150

94a

0777661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0777661

Registered No.

IRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Edward Mantler

2. DATE OF DEATH Aug. 27, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 2725 Fenwick Ave. 9-06

5. SEX M.

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 12/27/1872

9. AGE (In years last birthday) 76 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Repairer

10B. KIND OF BUSINESS OR INDUSTRY Md. Dry Dock

11. BIRTHPLACE (State or foreign country) Balto.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thomas Mantler

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-09-1380A

17. INFORMANT Linwood Mantler ADDRESS 2014 Bisbury St.

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Unknown

DUE TO

(B) Arteriosclerosis, Generalized

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 25, 1949, *to* Aug. 27, 1949, *that I last saw the deceased alive on* Aug. 27, 1949, *and that death occurred at* 11:20 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE James A. O'Dare M. D.

23B. ADDRESS 1400 N. Caroline St.

23C. DATE SIGNED Aug. 27, 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/30/49

24C. NAME OF CEMETERY OR CREMATORY Maryland Park

24D. LOCATION (City, town, or county) (State) Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm Cook Inc.

ADDRESS 1217 St. Paul St.

VS 150

83B

77662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077662

IRTH NO.

1. NAME OF DECEASED (Type or Print): George W. S. Kuhn

2. DATE OF DEATH: Aug. 27, 1949

3. PLACE OF DEATH: Baltimore City, Maryland 3201 St. Paul St.

FULL NAME OF OSPITAL OR NSTITUTION (If not in hospital or institution, give street address or location): 3201 St. Paul St.

Length of stay in Baltimore: 10 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3201 St. Paul St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 4, 1881
9. AGE (In years last birthday): 67 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe Coverer
10B. KIND OF BUSINESS OR INDUSTRY: Asbestos Works
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Kuhn
14. MOTHER'S MAIDEN NAME: Louisa ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 085 09 2642
17. INFORMANT: Margaret Kuhn ADDRESS: 3201 St. Paul St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage Rt — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
(B) Gen. Arteriosclerosis. — ?
DUE TO Hypertension.
(C) Bronchiogenic Carcinoma Lt. — 6 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 1, 1949 to Aug. 27, 1949 *that I last saw the deceased alive on* 8-27-, 19 49 *and that death occurred at* 5:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert H. Lowe M. D. | 23B. ADDRESS: Calvert & 30th St. 18 | 23C. DATE SIGNED: 8-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal | 24B. DATE: Aug. 29, 1949 | 24C. NAME OF CEMETERY OR CREMATORY: Fern Cliff | 24D. LOCATION (City, town, or county) (State): Hartsdale N.Y.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Wm. Cook Inc. ADDRESS: 1217 St. Paul St.

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077663 X ✓ 077663

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 Registered No.

1. NAME OF DECEASED (Type or Print) ROSS P. BROWN

2. DATE OF DEATH 8/28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Essex, Md. (If outside corporate limits, write RURAL and give township)

3B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gardenville Convalescent Home

3C. Length of stay in Baltimore — Yrs. life, Mos., Days

4D. STREET ADDRESS (If rural, give location) Island View Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	widower	April 10, 1876	73	4	18		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contractor	Concrete Construction	Baltimore, Md.	USA

13. FATHER'S NAME: John Brown

14. MOTHER'S MAIDEN NAME: Mary Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Miss June Brown — ADDRESS: Island View Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Syndrome — INTERVAL BETWEEN ONSET AND DEATH ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Terminal uremia

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 16, 1949 *to* Aug 28, 1949 *that I last saw the deceased alive on* Aug 27, 1949 *and that death occurred at* 1:35 A.m. *from the causes and on the date stated above.*

23A. SIGNATURE H. O. Harbold M. D. — 23B. ADDRESS 4706 Harford Road — 23C. DATE SIGNED Aug. 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	8/28/49	Parkwood	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949 VS T50

REGISTRAR'S SIGNATURE: Twitchyton Williams, M.D.

25. FUNERAL DIRECTOR: Lucabs Funeral Home — ADDRESS: 7401 Belair Rd.

93D

77664

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 49-17814

CERTIFICATE OF DEATH

77664 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Humphreys

2. DATE OF DEATH: Aug 16, 1949.

3. PLACE OF DEATH: Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ Hosp.

3b. Length of stay in Baltimore: 14 3/4 hrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 17-04
C. CITY OR TOWN: Balt. (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): Univ Hosp. (1213 Shields Place)

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single.
8. DATE OF BIRTH: Aug 16, 1949.
9. AGE (In years last birthday): If Under 1 Year: Months / Days; If Under 24 Hours: Hours 14, Min. 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Balt. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Levi Humphreys
14. MOTHER'S MAIDEN NAME: Mary Douglas 1213 Shields Place
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.: Unknown.
17. INFORMANT: Mother ADDRESS: Balt. Md.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Medullary carcinoma of adrenal gland due to
(B) Prematurity.
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 14 hrs. 45 min.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 16, 1949, to Aug 16, 1949, *that I last saw the deceased alive on* Aug 16, 1949, *and that death occurred at* 1130 Am., *from the causes and on the date stated above.*

23a. SIGNATURE: R. A. Abraham M.D. M. D.
23b. ADDRESS: Univ Hosp.
23c. DATE SIGNED: 8/24/49.

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24d. LOCATION (City, town, or county) (State): AUG 26 1949

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health.
ADDRESS

VS 150

159

77665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. BC. 49-17820 — Registered No. 77665

1. NAME OF DECEASED (Type or Print): Baby Boy Gray

2. DATE OF DEATH: 8-20-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

C. Length of stay in Baltimore: 22 hours. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2545 Madison ave.

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 8-19-49
9. AGE (In years last birthday) — If under 1 year: Months, Days — If under 24 hours: Hours 21, Min. 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Allen Weeks Donald Gray
14. MOTHER'S MAIDEN NAME: Mary Weeks
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS:

CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Pulmonary Atelectasis	12 hours.
	DUE TO (B)	Prematurity	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-19, 1949 *to* 8-20, 1949, *that I last saw the deceased alive on* 8-20, 1949, *and that death occurred at* 5:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jarrett E Deane M. D.
23B. ADDRESS: University Hosp. Balto Md
23C. DATE SIGNED: 8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): AUG 26 1949

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

159

77666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

581 D

Registered No. 077666

IRTH NO.

1. NAME OF DECEASED (Type or Print) TOBY STOLER

2. DATE OF DEATH AUG. 28, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN BALTIMORE (If outside corporate limits, write RURAL and give township) 8 04

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL

D. STREET ADDRESS (If rural, give location) 1218 N. PATTERSON PARK AVE.

Length of stay in Baltimore Life (Yrs. Mos. Days)

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE | 8. DATE OF BIRTH 1935 | 9. AGE (In years last birthday) 14 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Girl | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MARYLAND | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Herman Stoler

14. MOTHER'S MAIDEN NAME Annie Shafer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL ANOXEMIA

DUE TO CHRONIC BLOOD LOSS

ANTECEDENT CAUSES

DUE TO (B) ESOPHOGEAL VARICES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C) LAENNEC'S CIRRHOSIS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PERINEPHRIC ABSCESS

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION — | 19B. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) NONE | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) NONE | 21C. WHERE DID INJURY OCCUR? — (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* AUG. 24, 1949, *to* AUG. 28, 1949, *that I last saw the deceased alive on* AUG. 28, 1949, *and that death occurred at* 8:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Leon E. Kassel, Jr. M. D. | 23B. ADDRESS Sinai Hospital | 23C. DATE SIGNED 8/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8-29-49 | 24C. NAME OF CEMETERY OR CREMATORY Rosedale | 24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Jack Lewis Inc. | ADDRESS 2100 Gutow Rd

VS 150

124B

7667 BIRTH NO B.C. 49-17304

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 0777667

1. NAME OF DECEASED (Type or Print): Baby Girl Mac Intosh

2. DATE OF DEATH: August 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore: 11 hrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Middle River
D. STREET ADDRESS (If rural, give location): 13 Harrison Avenue #20

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	S.	August 18, 1949				11	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: George Stuart MacIntosh Jr.

14. MOTHER'S MAIDEN NAME: Grace Orem Edel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Grace MacIntosh — ADDRESS: 13 Harrison Avenue

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 18, 1949, *to* Aug. 18, 1949, *that I last saw the deceased alive on* Aug. 18, 1949, *and that death occurred at* 7:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Albert Greene M. D. | 23B. ADDRESS: Sinai Hospital | 23C. DATE SIGNED: 8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL AUG 22 1949 | 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Commissioner of Health | ADDRESS

VS 150

159

077668 BC-49-1494 BALTIMORE CITY HEALTH DEPARTMENT 593 077668
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Linda S. Lee
2. DATE OF DEATH 8/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1305 Pontiac Avenue 25-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Female	White	Single	8/15/49				2	21

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Samuel Lee
14. MOTHER'S MAIDEN NAME Jean M. Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) S Multiple congenital anomaly? — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/15/49, 19__, *to* 8/15/49, 19__, *that I last saw the deceased alive on* 8/15 1949, *and that death occurred at* 2:22 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE J. L. Hollister M. D.
23B. ADDRESS 1213 Light St
23C. DATE SIGNED 8/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY JOHN HOPKINS MEDICAL SCHOOL AUG 22 1949
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949
REGISTRAR'S SIGNATURE Municipal Registrar
25. FUNERAL DIRECTOR Commissioner of Health
ADDRESS

VS 150 MAY

157M

077669

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 077669

1. NAME OF DECEASED (Type or Print) Noah Mack

2. DATE OF DEATH Aug 26, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hosp.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN Balto (If outside corporate limits, write RURAL and give township) 28-01
D. STREET ADDRESS (If rural, give location) 7001 Reistertown Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	colored	Single	march 2, 1871	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	—	Md	

13. FATHER'S NAME John mack

14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Charles Becker	7001 Reistertown Rd

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pos. Pontine Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Essential Hypertension.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-25, 1949 *to* 8-26, 1949 *that I last saw the deceased alive on* 8-2, 19___ *and that death occurred at* 3:40 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis A Leeper M. D.	Provident Hosp.	8-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	aug 29, 1949	Finney Grove	Reistertown md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 29 1949	Twetzington Williams, M.D.	George D. Wilson	1303 Presstman St

VS 150

83a

077670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077670

IRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM Thomas T. BRANDON

2. DATE OF DEATH August 27, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New York
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New York
D. STREET ADDRESS (If rural, give location) 287 Third Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Separated	June 1878	71 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Advertising Business	Union City, Ohio	

13. FATHER'S NAME: Channig W. Brandon

14. MOTHER'S MAIDEN NAME: Josephine Archard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Miss Mary Brandon	1220 Madison Ave. Columbus 5, Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Paul L. Reyle M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED August 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	8/29/49	Greenmount Crem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 29 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 151

94a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 77671 — Registered No. 077671

1. NAME OF DECEASED (Type or Print): Peter Sinek

2. DATE OF DEATH: August 12, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1030 E. Lombard St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): U
8. DATE OF BIRTH: U
9. AGE (In years last birthday): 60?
If under 1 year: Months / Days
If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: N K O
11. BIRTHPLACE (State or foreign country): K
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: N O
14. MOTHER'S MAIDEN NAME: N O

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: N
17. INFORMANT: N — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: John R. Davis, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: August 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): AUG 24 1949

DATE RECEIVED BY REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 151

935

506 2/2

977672
IRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-1

977672
Registered No.

1. NAME OF DECEASED (Type or Print) Mary Barnes

2. DATE OF DEATH AUG 2 8 1949

3. PLACE OF DEATH: Baltimore City, Maryland

3. FULL NAME OF OSPITAL OR NSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1939 Harlem Ave 16-04

5. SEX Female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single | 8. DATE OF BIRTH 12-24-29 | 9. AGE (In years last birthday) 19 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of k done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Norman Barnes | 14. MOTHER'S MAIDEN NAME Blanche Goode

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (es, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured Appendix — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Generalized peritonitis.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 8/26/49 | 19B. MAJOR FINDINGS OF OPERATION Ruptured appendix & generalized p[illegible] | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (Give exact location) Peritonitis

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-26-, 1949 *to* 8-28-, 1949 *that I last saw the deceased alive on* 8-28-, 19___, *and that death occurred at* 12 48 *m., from the causes and on the date stated above.*

23A. SIGNATURE Gordon Malone Carver Jr. M.D. | 23B. ADDRESS JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED 8/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE aug. 31 | 24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial | 24D. LOCATION (City, town, or county) (State) Arbutus, Md.

DATE RECEIVED BY REGISTRAR AUG 29 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS Charles H. Alexander, 1200 Mcculloh St.

VS 150

121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 77673 — Registered No. 077673

1. NAME OF DECEASED (Type or Print): HARRY KECCAR — 2. DATE OF DEATH: 7-22-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): RESIDENT HOSPITAL

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD — B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1549 BRAGG AVE — 14-04

5. SEX: M — 6. COLOR OR RACE: Negro — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) — 8. DATE OF BIRTH: 12-26-94 — 9. AGE (In years last birthday): 54 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JANITOR — 10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN — 14. MOTHER'S MAIDEN NAME: IDA ANDERSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: — 17. INFORMANT: DECEASED — ADDRESS:

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	HYPOSTATIC PNEUMONIA	10 days.
DUE TO (B)	PROBABLE Ca PHOSCASTOMA (STOMACH)	6 MONTHS
DUE TO (C)		

19A. DATE OF OPERATION: NONE — 19B. MAJOR FINDINGS OF OPERATION: NONE — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NEITHER — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 9 1949 *to* July 22 1949, *that I last saw the deceased alive on* July 22, 1949, *and that death occurred at* 12 32 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Lucian C Wallace M. D. — 23B. ADDRESS: Provident Hosp. — 23C. DATE SIGNED: 8/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify) — 24B. DATE — 24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL — 24D. LOCATION (City, town, or county) (State): AUG 24 1949

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Commissioner of Health — ADDRESS

VS 150 — 55E

77674

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

493

077674

Registered No.

1. NAME OF DECEASED (Type or Print) Mathies Fountain

2. DATE OF DEATH 8/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md.
D. STREET ADDRESS (If rural, give location) 646 Sarah Ann St. Redwood & Greene Sts.

5. SEX M

6. COLOR OR RACE C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) U

8. DATE OF BIRTH U

9. AGE (In years last birthday) 40?
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY K

11. BIRTHPLACE (State or foreign country) K

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME N O

14. MOTHER'S MAIDEN NAME N O

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) N

16. SOCIAL SECURITY NO.

17. INFORMANT N ADDRESS

CAUSE OF DEATH

16. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure — DUE TO

(B) Septicemia - overwhelming Toxemia — DUE TO

(C) Klebsiella pneumoniae

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 5, 1949 *to* August 6, 1949, *that I last saw the deceased alive on* August 6, 1949, *and that death occurred at* 4:35 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE Fred L. McClure Jr. M. D.

23B. ADDRESS University Hospital

23C. DATE SIGNED 8/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State) AUG 21 1949

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Commissioner of Health — ADDRESS

VS 150

13B

0777675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 0777675

BIRTH NO.

1. NAME OF DECEASED (Type or Print)	Dr. Joseph Alter Rosenblatt
2. DATE OF DEATH	Aug. 28 1949
PLACE OF DEATH:	Baltimore City, Maryland
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	3915 Liberty Heights Ave
Length of stay in Baltimore	24 yrs. (Yrs. / Mos. / Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	3915 Liberty Heights Ave 15 10
5. SEX	Male
6. COLOR OR RACE	White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	Married
8. DATE OF BIRTH	March 22, 1891
9. AGE (In years last birthday) / If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.	58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Doctor Medical
10B. KIND OF BUSINESS OR INDUSTRY	Private Practice
11. BIRTHPLACE (State or foreign country)	Russia
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Alter Rosenblatt
14. MOTHER'S MAIDEN NAME	Ellen
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) / (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	
17. INFORMANT / ADDRESS	Mrs Marie K Rosenblatt Libertyheights

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs. Approximate.

DUE TO —

(B) —

DUE TO —

(C) —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —	19B. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1944 *to* Aug. 28, 1949, *that I last saw the deceased alive on* Aug. 26, 1949. *and that death occurred at* 2.30 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	Milton S. Sacks M. D.	
23B. ADDRESS	University Hospital	
23C. DATE SIGNED	8/28/49	
24A. BURIAL, CREMATION, REMOVAL (Specify)	Cremation	
24B. DATE	Aug 30, 1949	
24C. NAME OF CEMETERY OR CREMATORY	Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State)	Baltimore Maryland	
DATE RECEIVED BY LOCAL REGISTRAR	AUG 29 1949	
REGISTRAR'S SIGNATURE	Huntington Williams, MD	
25. FUNERAL DIRECTOR / ADDRESS	Sol Levinson & Bros W North Ave 1126	

VS 150

55E

333413 Med Exam. Case 155.

0777676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0777676

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Lucy Forrest

2. DATE OF DEATH AUG 24 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore — Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-04
D. STREET ADDRESS (If rural, give location) 830 N. Fulton Ave.

5. SEX female
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH
9. AGE (In years last birthday) 35 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) N. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Moses Huntley
14. MOTHER'S MAIDEN NAME Essie Mass

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS JOHNS HOPKINS HOSPITAL

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis & metastasis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO to liver. (over)
(B) Exploratory laboratory &
DUE TO Ventricular fibrillation
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 8/24/49
19B. MAJOR FINDINGS OF OPERATION Metastatic carcinoma of liver.
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If outside city or county, give town or county and state)
CERTIFICATION APPROVED BY Wm. G. Helfrich, M.D.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Approved by C. S. Lockwood M.D. CHIEF OR ASST. MEDICAL EXAMINER.

22. I hereby certify that I attended the deceased from 8-24- 1949 to 8-24- 1949, that I last saw the deceased alive on 8-24- 1949, and that death occurred at 1143 p.m., from the causes and on the date stated above.

23A. SIGNATURE Gordon Malone Carver Jr.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 8/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug. 30-49
24C. NAME OF CEMETERY OR CREMATORY Monroe
24D. LOCATION (City, town, or county) (State) N. C.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR James Stamps
ADDRESS 638 N. Gilmor St

VS 150 Medical Exp. Case Released to hospital 46F
To be approv. by Med Exam.

0776777

JL# 130574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 0776777

IRTH NO.

1. NAME OF DECEASED (Type or Print) George Hickman

2. DATE OF DEATH 8-27-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 58 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1033 Myrtle Ave. 12-07

5. SEX M

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Wid.

8. DATE OF BIRTH April 1, 1882

9. AGE (In years last birthday) 67 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) N. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Stephen Hickman

14. MOTHER'S MAIDEN NAME Patient Pellum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT B. C. H. Records, ADDRESS 4940 Eastern Ave.

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aneurysm of a descending Aorta at the ~~xxxx~~ arch c rupture

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hemothorax Massive

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [ ] NO [X]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-26-49, 19__, *to* Aug. 27, 19 49 *that I last saw the deceased alive on* Aug. 27 19 49, *and that death occurred at* 11pm m., *from the causes and on the date stated above.*

23A. SIGNATURE C. C. Vogan M. D.

23B. ADDRESS 4940 Eastern Ave.

23C. DATE SIGNED 8-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Aug 30-49

24C. NAME OF CEMETERY OR CREMATORY New Bunn

24D. LOCATION (City, town, or county) (State) N. C.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949

REGISTRAR'S SIGNATURE Tuttle for Williams, MD

25. FUNERAL DIRECTOR James A Hayes

ADDRESS 638 N. Gilmor St

30

VS 150

MEDICAL CERTIFICATION

777678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 777678

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Kemp, Mr. Herbert H.

2. DATE OF DEATH 8-26-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home + Hospital

Length of stay in Baltimore life (69) Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dundalk - 22
D. STREET ADDRESS (If rural, give location) 2020 Patapsico

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Sept 21, 1879 | 9. AGE (In years last birthday) 69 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY Patapsco/Back River RR.

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U-S.

13. FATHER'S NAME Kemp John

14. MOTHER'S MAIDEN NAME Belt Anna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Abdominal Abscess	1 day
	DUE TO (B) Perforation of bowel	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Acute Bronchitis	1 day

19A. DATE OF OPERATION 8-26-49 | 19B. MAJOR FINDINGS OF OPERATION Pelvic Peritonitis | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 26, 1949 *to* August 26, 1949 *that I last saw the deceased alive on* August 26 1949, *and that death occurred at* 5:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Ronald L. Eaton M. D. | 23B. ADDRESS Church Home + Hosp. | 23C. DATE SIGNED 8-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug. 29, 1949 | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Roland L. Fisher | ADDRESS 2112 Dundalk Ave.

VS 150

123

777679

RTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43

777679

Registered No.

NAME OF DECEASED (Type or Print): ELLA KEYS

2. DATE OF DEATH: Aug. 27, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 923 Myrtle Ave.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 923 Myrtle Ave. 17-21

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Single	May 30, 1895	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	Cook	Maryland	U. S. A

13. FATHER'S NAME: Joseph Keys

14. MOTHER'S MAIDEN NAME: Julia Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			George Keys	Eastern, Md.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension - Cardiac

DUE TO Vascular disease

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 14, 1949, *to* Aug 27, 1949, *that I last saw the deceased alive on* Aug 27, 1949, *and that death occurred at* 7:45 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm Danner M. D.	753 Cenect	8/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-30-49	Mt. Auburn Cem	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 29 1949	Huntington Williams, M.D.	Mrs. Frances A. Hemsley	578 W Biddle St.

VS 150

937

077680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

077680 Registered No.

RTH NO.

NAME OF DECEASED (Type or Print) WILLIAM SCOTT

2. DATE OF DEATH Aug. 25, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1037 S. Sharp Street

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 1037 S. Sharp St. 23-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (in years) last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Widower	July 15, 1879	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY BRICKYARD

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Julia Cannaday

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.

16. SOCIAL SECURITY NO. 215-05-7716

17. INFORMANT Mrs. Mazie Scott ADDRESS 1037 S. Sharp St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Cardio-Renal Disease
DUE TO
ANTECEDENT CAUSES
(B) age (?)
DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH Unknown

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 22, 1949 *to* Aug. 25, 1949 *that I last saw the deceased alive on* Aug 25, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE John W. Gaines M. D.

23b. ADDRESS 507 W. Hamburg St

23c. DATE SIGNED 8/27/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8-30-49

24c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem

24d. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Mrs. Frances A. Hemsley 578 W. Biddle

VS 150

131a

077681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 077681

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Anna M. Mc Donough — 2. DATE OF DEATH Aug 26/49

3. PLACE OF DEATH: a. Baltimore City, Maryland 1527 N. Patterson — b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) P.R. Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltmore — B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 8-04

d. Length of stay in Baltimore Life (Yrs. Mos. Days) — D. STREET ADDRESS (If rural, give location) 1527 N. Patterson P.R. Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months	Days	If under 24 Hours: Hours	Min.
Female	W.	Married	May 5/1903	46	3	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore	

13. FATHER'S NAME Sylvester Marsalek — 14. MOTHER'S MAIDEN NAME Anna Machovec

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Alfred J. Mc Donough ADDRESS 1527 N. Patt. Ave

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Cerebral Hemorrhage	5 days
DUE TO (B)	Arterial hypertension & sclerosis, with myocardial hypertrophy	5 yrs -
DUE TO (C)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Cerebral Hemorrhage Hemiplegia	1 yr

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1 1949, to Aug 26, 1949 that I last saw the deceased alive on Aug 25, 1949, and that death occurred at 1:30 P m., from the causes and on the date stated above.

23A. SIGNATURE Elmer L. Harden Jr. M. D. — 23B. ADDRESS 3900 Clarks Rd — 23C. DATE SIGNED 8/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE 8/30/49 — 24C. NAME OF CEMETERY OR CREMATORY Sacred Heart — 24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949 — REGISTRAR'S SIGNATURE Huntington Williams, MD — 25. FUNERAL DIRECTOR Philip Herrig Sons — ADDRESS 2024 Orleans St

VS 150

93E 31

977682

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

470 1

977682

Registered No.

1. NAME OF DECEASED (Type or Print) John Clough

2. DATE OF DEATH 8/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1420 Hanover St

C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 23-01
D. STREET ADDRESS (If rural, give location) 1420 Hanover St

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married (Sep)
8. DATE OF BIRTH August 27 1883
9. AGE (In years last birthday) 65
If Under 1 Year: Months — Days
If Under 24 Hours: Hours — Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper
10B. KIND OF BUSINESS OR INDUSTRY Glass Mfg.
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 217-07-7761

17. INFORMANT Mr John Clough (Son) ADDRESS 1420 Hanover

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection Autopsy, Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE John R Ward M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED 8/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1949 August 30
24C. NAME OF CEMETERY OR CREMATORY Holy Cross
24D. LOCATION (City, town, or county) Annapolis (State) Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR John F Kenny Inc ADDRESS 711 Eight St

VS 151

94a

077683

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 077683

1. NAME OF DECEASED (Type or Print): ALEXANDER THOMPSON DUKES

2. DATE OF DEATH: Aug. 26, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wyman Park Apts.

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): Wyman Park Apts. 12-7

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Dec. 11, 1876
9. AGE (In years last birthday): 72 yrs. If Under 1 Year: Months: Days. If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesmanager
10B. KIND OF BUSINESS OR INDUSTRY: Fertilizer Business
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Isaac R. Dukes
14. MOTHER'S MAIDEN NAME: Ida Neilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Mabel K. Dukes ADDRESS: Wyman Park Apts.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Aug 26. 1949

DUE TO

(B) Coronary thrombosis — Mar 27. 1949

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar 27, 1949, to Aug 26, 1949, *that I last saw the deceased alive on* Aug 26, 1949, *and that death occurred at* 10.43 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thos D Bubert M. D.
23B. ADDRESS: 1803 Eutaw Heights Ave
23C. DATE SIGNED: Aug 27. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/29/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Tuntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

94a

977684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163

977684

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): James Lafayette Reese

2. DATE OF DEATH: 8/28/49

3. PLACE OF DEATH: a. Baltimore City, Maryland ✓

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: 18 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN: Baltimore, Maryland 12-1 (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): Ambassador Apts - 29 St + Canterbury Rd.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug. 9 1889
9. AGE (In years last birthday): 60
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retail Whsle Supply Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Electrical business
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Sherman Reese
14. MOTHER'S MAIDEN NAME: Augusta Burnett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Lee Reese ADDRESS: Edmondson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ? Terminal Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 min

DUE TO

(B) Auricular fibrillation — 5 hrs.

DUE TO

(C) Post-op. complications - Rt. Pneumonectomy — 3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Carcinoma Rt. lung.

19A. DATE OF OPERATION: 8-25-49 (Pneumonectomy) Rt
19B. MAJOR FINDINGS OF OPERATION: Carcinoma - Rt. lung & hilar metastases
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 5, 1949 *to* Aug. 28, 1949 *that I last saw the deceased alive on* Aug 28, 1949, *and that death occurred at* 3.10 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert W. Garis M.D.
23B. ADDRESS: 1103 St. Paul St.
23C. DATE SIGNED: 8/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Entombment
24B. DATE: 8/31/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem. Maus.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

47D

7685

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

077685

Registered No.

1. NAME OF DECEASED (Type or Print): MAURER, WILLIAM L.

2. DATE OF DEATH: 8/25/49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

Length of stay in Baltimore: 40 Yrs. ~~Mons~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2607 LIST AVE.

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M

8. DATE OF BIRTH: 1909 - Mar. 28

9. AGE (In years last birthday): 40
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GROCER - PROP.

10B. KIND OF BUSINESS OR INDUSTRY: GROCER SELF

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: WILLIAM MAURER

14. MOTHER'S MAIDEN NAME: MARGARET DEHLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ?
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: WIFE
ADDRESS: Amelia Maurer - 2607 List Ave.

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HEART FAILURE

DUE TO

(B) CORONAY THROMBOSIS
MYOCARDIAL INFARCTION

DUE TO

(C) RENAL SHUTDOWN

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: NONE

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/21/49, 19__, to 8/25/49 19__, *that I last saw the deceased alive on* 8/25/1949, *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: J. G. Heuerhard Jr. M. D.

23B. ADDRESS: University Hospital

23C. DATE SIGNED: 8/25/49

24A. BURIAL, CREMATION OR REMOVAL (Specify): Burial

24B. DATE: 8-29-49

24C. NAME OF CEMETERY OR CREMATORY: Oaklawn

24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Leonard J. Luck

ADDRESS: 5305 Harford Rd

VS 150

94a

77686

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077686

1. NAME OF DECEASED (Type or Print): CHARLES SWEITZER, JR.

2. DATE OF DEATH: Aug. 26, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 402 Woodford Rd.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE: Md.

b. COUNTY:

c. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)

d. STREET ADDRESS (If rural, give location): 402 Woodford Rd.

5. SEX: ale

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July 7, 1891

9. AGE (In years last birthday): 58 yrs. | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): uditor

10B. KIND OF BUSINESS OR INDUSTRY: Oil Business

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: harles Sweitzer

14. MOTHER'S MAIDEN NAME: Rose Seifert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes

(If yes, give war or dates of service): World War #1

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Myrtle M. Sweitzer

ADDRESS: 402 Woodford Rd.

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO

(B) Arteriosclerosis — 1 yr.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 25 1949 *to* Aug. 26, 1949 *that I last saw the deceased alive on* Aug. 25 1949, *and that death occurred at* 10:30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Karl A Bevan. M.D. M. D.

23B. ADDRESS: 5111 York Rd.

23C. DATE SIGNED: Aug. 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 8/30/49

24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS

ADDRESS: Balto., Md.

VS 150

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0776B7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170

0776B7

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BARBARA DOROTHY BLACK

2. DATE OF DEATH AUGUST 26, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs hospital

Length of stay in Baltimore — Yrs. NINE YEARS — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE MARYLAND
B. COUNTY Baltimore
C. CITY OR TOWN BALTIMORE (If outside corporate limits, write RURAL, and give township) Essex
D. STREET ADDRESS (If rural, give location) 1605 RICKENBACKER ROAD

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED
8. DATE OF BIRTH 6/27/1912
9. AGE (In years last birthday) 37
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assorter Crown cORK
10B. KIND OF BUSINESS OR INDUSTRY CROWN CORK AND SEAL
11. BIRTHPLACE (State or foreign country) NEW CASTLE, DELAWARE
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME John Black
14. MOTHER'S MAIDEN NAME Mary. Mary Hopkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 577-11-7437

17. INFORMANT Gertrude Stricks ADDRESS Essex

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PULMONARY METASTATIC CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH: APP 3 Mo

DUE TO

(B) CARCINOMA BREAST

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 1947
19B. MAJOR FINDINGS OF OPERATION CARCINOMA BREAST
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JULY 19, 1949, *to* AUGUST 26, 1949 *that I last saw the deceased alive on* AUG. 26, 1949, *and that death occurred at* 6:50P m., *from the causes and on the date stated above.*

23A. SIGNATURE Eugene L Lehr M.D. M. D.
23B. ADDRESS ST JOSEPH'S HOSPITAL
23C. DATE SIGNED 8/26/1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug 30-49
24C. NAME OF CEMETERY OR CREMATORY Sacred Heart
24D. LOCATION (City, town, or county) (State) Balto., Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949
REGISTRAR'S SIGNATURE Huntington Matthews, M.D.
25. FUNERAL DIRECTOR John G. Connelly
ADDRESS 418 Eastern Ave Balto, 21, Md

VS 150

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077688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331 Registered No. 077688

BIRTH NO.

NAME OF DECEASED (Type or Print) Mary Kraus

2. DATE OF DEATH August 27 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home for Aged Little Sisters of the Poor 1200 Valley St. - Baltimore

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Balto (If outside corporate limits, write RURAL and give township) 1.6 - 01
D. STREET ADDRESS (If rural, give location) 1200 Valley St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In Years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
F	W.	W	April 7 1861	88		20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Christian Gertel

14. MOTHER'S MAIDEN NAME Marion Bauchalert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Little Sisters of the Poor. ADDRESS 1200 Valley St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 4 days

DUE TO

(B) Arteio Sclerosis — 10 yr

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 23, 1949, to Aug 28, 1949, *that I last saw the deceased alive on* Aug 27, 1949, *and that death occurred at* 5:45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE E. Gill Hall M. D.

23B. ADDRESS 1631 E North Ave

23C. DATE SIGNED Aug-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/29/49

24C. NAME OF CEMETERY OR CREMATORY Loudon Pk.

24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949

REGISTRAR'S SIGNATURE Huntington Matthews, M.D.

25. FUNERAL DIRECTOR Rita Wiedefeld

ADDRESS 900 E. Biddle St

VS 150

83a 2

977689

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E-112-0

A-855

Registered No. 977689

1. NAME OF DECEASED (Type or Print) ELLWOOD WILLIAMS Or Elmore Williams

2. DATE OF DEATH August 23, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

Length of stay in Baltimore 12 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 112 N. Bond St 6-05

5. SEX male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Sept. 19-1917
9. AGE (In years last birthday) 31 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or Foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mildred Gregg ADDRESS 112 N. Bond St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intra-cranial Hemorrhage

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B) Fracture of Pelvis
DUE TO
(C) Amputation - Rt. leg.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Market Place and Water Street 4/1
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 23, 1949 9 p.m.
21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Run over by rear wheel of truck

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L. Gregg M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED August 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Aug. 28 49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.
24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949
REGISTRAR'S SIGNATURE Limbaugh Williams, M.D.
25. FUNERAL DIRECTOR Chas G. Wilson ADDRESS 1000 Bonita

VS-A80

170c

077690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1 Registered No. 077690

BIRTH NO.

NAME OF DECEASED (Type or Print) Joseph Gaskins

2. DATE OF DEATH Aug 26 - 49

PLACE OF DEATH: Baltimore City, Maryland 2544 Frances St

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ✓

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 2544 Frances St B. COUNTY Balto md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13th
D. STREET ADDRESS (If rural, give location) 2544 Frances St

Length of stay in Baltimore — Yrs. Mos. Days

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Married		74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elevator keeper
10B. KIND OF BUSINESS OR INDUSTRY: Self Merchandize
11. BIRTHPLACE (State or foreign country): Westmoreland Co Va
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Dennis Gaskins
14. MOTHER'S MAIDEN NAME: Eliza Richardson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Alice Gaskins ADDRESS: 1607 Millsman St

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Mitral Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 25 1949 *to* Aug 26 1949, *that I last saw the deceased alive on* Aug 26 1949, *and that death occurred at* 11 57 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Edward Fisher M. D. | 23B. ADDRESS: 1612 E. Monument St | 23C. DATE SIGNED: 8-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 8-29-49 | 24C. NAME OF CEMETERY OR CREMATORY: Mt. Albion Cemetery | 24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, MD | 25. FUNERAL DIRECTOR: William A Jackson | ADDRESS: 916 Pennsylvania Ave

VS 150

937

977691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

581 0

977691 Registered No.

IRTH NO.

1. NAME OF DECEASED (Type or Print) Thomas A. Mc Guire

2. DATE OF DEATH 8/27/49

3. PLACE OF DEATH: Baltimore City, Maryland 1603 Lindenave

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1603 Linden Ave

Length of stay in Baltimore 21 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1603 Linden Ave 14-01

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH June 1-1889
9. AGE (In years last birthday) 60
If Under 1 Year: Months 2, Days 26
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman
10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co
11. BIRTHPLACE (State or foreign country) Barton - Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME James Mc Guire
14. MOTHER'S MAIDEN NAME Margaret Malloy
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Jas. Mc Guire ADDRESS Cumberland-Md

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic nephritis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

(B) Cirrhosis of liver — 6 mos.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 22, 1949 *to* Aug. 27, 1949 *that I last saw the deceased alive on* Aug. 26, 1949, *and that death occurred at* 1010A m., *from the causes and on the date stated above.*

23A. SIGNATURE M. Mc Dermott M. D.
23B. ADDRESS 1136 Poplar Grove St
23C. DATE SIGNED 8/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8/30/49
24C. NAME OF CEMETERY OR CREMATORY Mt Olivet Cem
24D. LOCATION (City, town, or county) (State) Washington D. C.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949
REGISTRAR'S SIGNATURE Washington Williams, MD
25. FUNERAL DIRECTOR John J. Cowan & Son
ADDRESS 124 B Holliday St.

7692

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

554

Registered No. 077692

1. NAME OF DECEASED (Type or Print) ANTHONY WEIGAND

2. DATE OF DEATH 8/27/49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2115 E. FAYETTE ST.

c. Length of stay in Baltimore LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2115 E. FAYETTE ST.

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH 1/17/1877

9. AGE (In years last birthday) 72 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER

10B. KIND OF BUSINESS OR INDUSTRY PRINTING

11. BIRTHPLACE (State or foreign country) MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME CONRAD WEIGAND

14. MOTHER'S MAIDEN NAME ANTIONETTE ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. ?

17. INFORMANT EDGAR WEIGAND ADDRESS SAME

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF RECTUM WITH METASTASES — INTERVAL BETWEEN ONSET AND DEATH 1½ yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/24/, 1949 *to* 8/27/, 1949, *that I last saw the deceased alive on* 8/27/, 1949, *and that death occurred at* 5:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Benj. B. Moss M. D.

23B. ADDRESS 444 N. Lafayette Ave

23C. DATE SIGNED 8/29/49

24A. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL

24B. DATE 8/31/49

24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER

24D. LOCATION (City, town, or county) (State) BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949

REGISTRAR'S SIGNATURE Twatterington Williams, MD

25. FUNERAL DIRECTOR WILLIAM J. ZEILER INC. ADDRESS BALTO.

VS 150

463

77693

JL - 130814

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 077693

1. NAME OF DECEASED (Type or Print) Benjamin Richard Moran

2. DATE OF DEATH 8-28-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 3713 Benefit Lane

Length of stay in Baltimore: Yrs. Life Mos. Days 26 0 9

5. SEX M
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 26, 1877
9. AGE (In years last birthday) 72
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10B. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Patrick Moran
14. MOTHER'S MAIDEN NAME Katie Kallery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT B. C. H. Records, ADDRESS 4949 Eastern Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cholemia
DUE TO
(B) Carcinoma of the common bile duct.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 8-10-49
19B. MAJOR FINDINGS OF OPERATION Explatory Laparotomy
20. AUTOPSY? YES ☐ No NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-4-49, 19__, *to* Aug. 28, 1949 *that I last saw the deceased alive on* Aug. 28, 1949, *and that death occurred at* 6.50 AM, *from the causes and on the date stated above.*

23A. SIGNATURE R. L. Rogers M. D.
23B. ADDRESS 4940 Eastern Ave.
23C. DATE SIGNED 8-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 9/1/49
24C. NAME OF CEMETERY OR CREMATORY St. Pauls 5th Reformed
24D. LOCATION (City, town, or county) (State) Balto. Md.
25. FUNERAL DIRECTOR Lilly & Leiler Inc. ADDRESS Balto.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.

VS 150

46F

7694

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

Registered No. 077694

1. NAME OF DECEASED (Type or Print) DORA WUESTLAND

2. DATE OF DEATH 8/24/1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 404 S. EDEN ST.

Length of stay in Baltimore Yrs. LIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 404 S. EDEN ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	WIDOWED	8/15/1875	74	3	0 Y

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	MD.	U.S.A.

13. FATHER'S NAME JACOB KING

14. MOTHER'S MAIDEN NAME MARIE ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	?	LOUISE WUESTLAND	SAME

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Anaemia.
DUE TO
(B) Myocarditis Chronic.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Hypertension Arteriol

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 days. [illegible] [illegible]

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none.	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	none	none.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	none.

22. *I hereby certify that I attended the deceased from* July 30, 1949, *to* Aug 23, 1949, *that I last saw the deceased alive on* Aug 23, 1949, *and that death occurred at* 1:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas Graham Martin M. D.	516 Cathedral St.	Aug 27, 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	8/27/49	ST. MATTHEW'S	BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 29 1949	Huntington Williams, M.D.	LILLY & ZEILER	BALTO. MD.

VS 150

93D

977695
JL- 129213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 977695

IRTH NO.

1. NAME OF DECEASED (Type or Print) John Palasik

2. DATE OF DEATH 8-27-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore — Yrs. Life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2225 Bank St. -24 1-05

5. SEX M

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Nov. 29, 1879

9. AGE (In years last birthday) 69
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Anthony (D)

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT B. C. H. Records, 4940 Eastern Ave. ADDRESS

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Far advanced Pulmonary Tuberculosis ~~with~~ no cavitation — Interval between onset and death: 6 mos

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute Pneumonic disease (spread of Tb.) — 3 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES Yes NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-25-49, 19__, *to* Aug. 27, 1949, *that I last saw the deceased alive on* Aug. 27, 19 49 *and that death occurred at* 6.25 AM *from the causes and on the date stated above.*

23A. SIGNATURE P. T. Logan M. D.

23B. ADDRESS 4940 Eastern Ave.

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE aug 31/49

24C. NAME OF CEMETERY OR CREMATORY Holy Rosary

24D. LOCATION (City, town, or county) (State) Balto. County

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John H. Weber ADDRESS 401 S. Chester St

VS 150

13B 1

✓X

277696

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

601 Registered No. 277696

1. NAME OF DECEASED (Type or Print): EDNA WATKINS

2. DATE OF DEATH: Aug 29, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSP.

Length of stay in Baltimore: Yrs. — Mos. — Days: 10

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: PENNA
B. COUNTY: Franklin
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WAYNESBORO
D. STREET ADDRESS (If rural, give location): 609 E MAIN ST.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: DEC 29, 1909
9. AGE (In years last birthday): 39 41
If Under 1 Year: Months — Days
If Under 24 Hours: Hours — Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: ALDRICH VISINA
14. MOTHER'S MAIDEN NAME: GEORGIANNA CONNOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal failure
DUE TO
(B) Bilat. hydronephrosis
DUE TO
(C) NEUROGENIC BLADDER — 11 yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 16, 1949 *to* Aug 29, 1949 *that I last saw the deceased alive on* Aug 29, 1949 *and that death occurred at* 4 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Gene D. Trostin M. D.
23B. ADDRESS: Mercy Hosp.
23C. DATE SIGNED: Aug 29 '49

24A. BURIAL, CREMATION, REMOVAL (Specify): removal
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: St Marys Cemetery
24D. LOCATION (City, town, or county) (State): Waynesboro Franklin Pa

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Tuntington Williams M.D.
25. FUNERAL DIRECTOR — ADDRESS: Walter Grove — 27 South Church St. Waynesboro Pa

VS 150

133B

77697

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077697

1. NAME OF DECEASED (Type or Print)	John Albert Wesley
2. DATE OF DEATH	Aug-26-1949
3. PLACE OF DEATH: Baltimore City, Maryland	Baltimore
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	2610 Pierpont Str.
Length of stay in Baltimore	74 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore 30 25-33
D. STREET ADDRESS (If rural, give location)	2610 Pierpont Street
5. SEX	male
6. COLOR OR RACE	Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	married
8. DATE OF BIRTH	Dec-18-1875
9. AGE (If under 1 year, last birthday)	73
If Under 1 Year: Months / Days	
If Under 24 Hours: Hours / Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	retired laborer
10B. KIND OF BUSINESS OR INDUSTRY	Basket-factory
11. BIRTHPLACE (State or foreign country)	Baltimore
12. CITIZEN OF WHAT COUNTRY?	U.S.A.
13. FATHER'S NAME	Mathew Wesley
14. MOTHER'S MAIDEN NAME	Nancy ~~Ho~~ Grant
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	no
16. SOCIAL SECURITY NO.	213-09-7214
17. INFORMANT	Wife Amelia Wesley
ADDRESS	2610 Pierpont St

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO

(B) cardio-vascular - renal disease — not known

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Hypertension — not known

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Accidental ulcers. Pernicious Anemia — 3 weeks

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July-6-1949 to Aug-26-1949, that I last saw the deceased alive on Aug-25-1949, and that death occurred at 7 55 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walther H Sonnentelat M. D.	2708 Hollins Ferry Rd.	8-26-49
24A. BURIAL, CREMATION OR REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY
Burial	8-30-49	W. L. Auburn
24D. LOCATION (City, town, or county) (State)	Balto. Md	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 29 1949	Kenneth Williams, M.D.	Mrs. Hattie R. Williams

VS 150

1310

77698

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 Registered No. 077698

1. NAME OF DECEASED (Type or Print) ROSS, BLANCHE

2. DATE OF DEATH 8-25-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE M D.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1 18-01
D. STREET ADDRESS (If rural, give location) 843 W. Fairmount Ave.

5. SEX F.
6. COLOR OR RACE B
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W
8. DATE OF BIRTH March 2 1893
9. AGE (In years last birthday) 56
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Howard Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?
14. MOTHER'S MAIDEN NAME Eliza Plummer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.

17. INFORMANT Arthur Simms ADDRESS 1738 Orleans St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — DUE TO
(B) Essential Hypertension — DUE TO
(C) Internal hemorrhoids (bleeding) Pulmonary Congestion & edema. Chronic leg ulcer. Hyp. CVDis.; Arteriosclerosis — DUE TO
(D) Secondary anemia.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) 12 hrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-24 1949, *to* 8-25 1949 *that I last saw the deceased alive on* 8-25 1949, *and that death occurred at* 12:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE W. A. Niemann M. D.
23B. ADDRESS Univ. Hosp.
23C. DATE SIGNED 8/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 8-29-49
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State) Beltsville Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mrs. Kate R. Williams
ADDRESS 937

VS 150

877699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

877699 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Michael L. O'Conn (Michael L.J.O'Connor)

2. DATE OF DEATH 8/28/47

PLACE OF DEATH: Baltimore City, Maryland Mercy Hosp

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

Length of stay in Baltimore 50 Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-09
D. STREET ADDRESS (If rural, give location) 1415 East Lanvale Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	Jan. 3, 1899	50	7	25

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post office clerk
10B. KIND OF BUSINESS OR INDUSTRY Post office
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph P. O'Connor
14. MOTHER'S MAIDEN NAME Sarah Dempsey Sara Dempsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Miss. Anna M.O'Connor ADDRESS 1415 E. Lanvale St Baltimore, Md.

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I
(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia — 7 days

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/14 19 47 *to* 8/28 19 47, *that I last saw the deceased alive on* 8/28 19 47 *and that death occurred at* 12 15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE C. Richard Frank M. D.
23B. ADDRESS Mercy Hosp
23C. DATE SIGNED 8/29/47

24A. BURIAL, CREMATION, REMOVAL (Specify) 24B. DATE 8-31-49
24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State) Edmondson Ave, BaltoMd.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR George J. Ruth, Inc., ADDRESS 1735 Harford Ave.

VS 150

832

177700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 17°

Registered No. 177700

BIRTH NO.

NAME OF DECEASED (Type or Print) ~~Elizabeth Mary O'Brien~~ ELIZABETH O'BRIEN

2. DATE OF DEATH 26 AUG 49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Hospital & Inf. 27 N.Carey Street

Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY City
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) I422 N.Bethel Street 8 07

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH I2-2I-I880
9. AGE (In years last birthday) 68 If Under 1 Year Months 10 Days 3 If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Silberzahn
14. MOTHER'S MAIDEN NAME Margaret Ledderman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mr.Louis H.Silberzahn--I7I0 N.Regester St. ADDRESS ~~Balto:Md.~~

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the breast. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 22 Aug, 1949, *to* 26 Aug, 1949, *that I last saw the deceased alive on* 26 Aug, 1949, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Emil H. Henning Jr M.D.
23B. ADDRESS 4580 Edmondson Ave
23C. DATE SIGNED 27 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE 8-30-49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State) Belair Rd.Balto:Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG.29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR George J.Ruth,Inc. ADDRESS I735 Harford Avenue

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49° Registered No. 077701

077701
BIRTH NO.

1. NAME OF DECEASED (Type or Print) MAYNARD MOSELY M

2. DATE OF DEATH. August 27, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 119 East Street

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital

Length of stay in Baltimore 10 yrs (Yrs. Mos. Days)

5. SEX male

6. COLOR OR RACE colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Sungle

8. DATE OF BIRTH April 18, 1920

9. AGE (In years last birthday) 29
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY ODD JOBS

11. BIRTHPLACE (State or foreign country) Brunswick, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Leonard Mosley

14. MOTHER'S MAIDEN NAME Mildred Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO. 223-20-8794

17. INFORMANT Mildred Mosley-119 East St ADDRESS 22

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar pneumonia

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Partial Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☑
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED August 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 8/30/49

24C. NAME OF CEMETERY OR CREMATORY Baltimore National

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Chas.R.Law ADDRESS 802 Madison Avenue-1

VS 151

108

077702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59

077702

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KATHERINE E. HUGHES

2. DATE OF DEATH: 8/26/49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 528 East 21st Street

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2247 Kirk Avenue

9-08

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1878
9. AGE (In years last birthday): 71 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John O'Connell
14. MOTHER'S MAIDEN NAME: Mary (?)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): O
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Mrs John Duley ADDRESS: 528 E. 21st St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gen. Arteriosclerosis
DUE TO
(B) Chr. Nephritis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Aug, 1949 *to* Aug 24, 1949, *that I last saw the deceased alive on* Aug 24, 1949, *and that death occurred at* 1.14 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Samuel L. Lowe, M. D.
23B. ADDRESS: 1761 E. Mass Ave
23C. DATE SIGNED: 8/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/29/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): City

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Lurlyn Williams, MD
25. FUNERAL DIRECTOR: WIEDEFELD & SON
ADDRESS: GREENMOUNT AVE & 22ND

131a

077703 ✓ 077703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. — Registered No. 60

1. NAME OF DECEASED (Type or Print): Anna M. Schweizer

2. DATE OF DEATH: 8-27-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4704 Schley Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Married	Nov 7 1877	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife		Baltimore Md	

13. FATHER'S NAME: John Voky

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT: Karl N. W. Schweizer — ADDRESS: 4704 Schley Ave

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

(C) Diabetes

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Senile Decay

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-20-49	Fractured Right Femur	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-20 19 49 *to* 8-27 19 49, *that I last saw the deceased alive on* 8-27 19 49, *and that death occurred at* 11:55 *a. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[illegible] M. D.	Mercy Hosp	8-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 30-1949	Moreland Memorial	Balto Md

DATE RECEIVED BY REGISTRAR: Aug 31 1949 — REGISTRAR'S SIGNATURE: [illegible] for Wilhelmina Mills M.D.

25. FUNERAL DIRECTOR: Wm. Fred John & Tenfelder Son — ADDRESS: 5311 Edmondson Ave

VS 150

122a

Frome

077704 BALTIMORE CITY HEALTH DEPARTMENT 077704

CERTIFICATE OF DEATH

143 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Herman Wm. Frome

2. DATE OF DEATH Aug. 28, 49

3. PLACE OF DEATH: Baltimore City, Maryland Univ. of Md. Hosp.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) #703 Hemprath Ave. Balto Md.

Length of stay in Baltimore 78 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18
D. STREET ADDRESS (If rural, give location) 1721 Montpelier St. 9-07

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH May 4 1871 | 9. AGE (In years last birthday) 78 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired machinist | 10B. KIND OF BUSINESS OR INDUSTRY Tin mill | 11. BIRTHPLACE (State or foreign country) Baltimore | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Christian Frome | 14. MOTHER'S MAIDEN NAME Elizabeth Koch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Archer Frome. ADDRESS 2115 Lincoln Lane. Balto. 13

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH 1 wk

DUE TO

(B) Hypertensive C-V disease

DUE TO

(C) Generalized arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

19A. DATE OF OPERATION None | 19B. MAJOR FINDINGS OF OPERATION None | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) None | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) None | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ None | 21F. HOW DID INJURY OCCUR? None

22. *I hereby certify that I attended the deceased from* Aug. 19 44, *to* Aug. 28 19 49, *that I last saw the deceased alive on* Aug. 26 19 49, *and that death occurred at* 1:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE J. Carl Myers M. D. | 23B. ADDRESS 1533 E. Coldspring Lane. Balto. 12. | 23C. DATE SIGNED Aug. 28, 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug 31-1949 | 24C. NAME OF CEMETERY OR CREMATORY London Park | 24D. LOCATION (City, town, or county) (State) Baltimore City

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Mr. Wm. John M. Teufel Son | ADDRESS 5311 Edmondson Ave 93D

VS 150

7705 BALTIMORE CITY HEALTH DEPARTMENT 077705

CERTIFICATE OF DEATH

H 201 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Minna Altman

2. DATE OF DEATH Aug 28/49

3. PLACE OF DEATH: Baltimore City, Maryland Georgian Ct. Apt

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore Lifetime Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 12-1
D. STREET ADDRESS (If rural, give location) Lutherlan & Brooklawn

5. SEX F | 6. COLOR OR RACE W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S.

8. DATE OF BIRTH Dec 2/1892 | 9. AGE (In years last birthday) 86 | If Under 1 Year: Months 8, Days 26 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Nathaniel Altman

14. MOTHER'S MAIDEN NAME Belle Jacobi

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO Coronary sclerosis; arteriosclerosis, generalized

(B) Hypertensive excessive — INTERVAL BETWEEN ONSET AND DEATH: 5 years +

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1947, to 28 Aug., 1949, *that I last saw the deceased alive on* Mar., 1947, *and that death occurred at* 6.45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Tom P. Hamburger Jr., M. D. | 23B. ADDRESS JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE Aug 30/49 | 24C. NAME OF CEMETERY OR CREMATORY Ohel Shalom | 24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Louis Goodlein | ADDRESS 1402 Eutaw Pl

VS 150

94a

7706 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Vol. 1 — Registered No. 077706

NAME OF DECEASED (Type or Print): W James Francis Heyward

2. DATE OF DEATH: Aug 27 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1001 St Paul St.

Length of stay in Baltimore: 60 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1001 St Paul St. 11-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	Married	Mar 19 1856	93		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNKNOWN	Retired - RAILROAD	Wilmington Del	USA.

13. FATHER'S NAME: James Francis Heyward

14. MOTHER'S MAIDEN NAME: Maria Presstman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mary Heyward — ADDRESS: 662 Register Ave

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Thrombosis	1 min
DUE TO (B)	Myocardial Insufficiency	1 week
DUE TO (C)	Pulmonary Edema	1 day
	Arterio Sclerosis	Years.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 15th, 1949, to Aug. 27th, 1949, *that I last saw the deceased alive on* Aug 27th, 1949, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. A. Chatard, M. D. — 23B. ADDRESS: 1300 E. Cold St. Balto Md. — 23C. DATE SIGNED: Aug. 29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: Aug 30/49 — 24C. NAME OF CEMETERY OR CREMATORY: Green Mount — 24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Henry McPerkins & Sons Co. — ADDRESS: 4905 York Rd

VS 150

94a

0777707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

Registered No. 0777707

IRTH NO.

1. NAME OF DECEASED (Type or Print): ANNA LORRETTA RUBY

2. DATE OF DEATH: Aug. 27, 1949

3. PLACE OF DEATH: Baltimore City, Maryland 816 N. Belnord Ave.

FULL NAME OF OSPITAL OR NSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 816 N. Belnord Avenue 7-02

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug. 15, 1888
9. AGE (In years last birthday): 61
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of k done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Luke McLaughlin
14. MOTHER'S MAIDEN NAME: Kate Casey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Frank J. Ruby-husband, ADDRESS: 816 N. Belnord Ave.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) Hypertensive Cardio-Vascular Disease — 3-4 yrs.
DUE TO
(C) Diabetes Mellitus — 4 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS—CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): none
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 31, 1946 to August 27, 1949 that I last saw the deceased alive on Aug 25, 1949, and that death occurred at 1050 a.m., from the causes and on the date stated above.

23A. SIGNATURE: Francis J. Jannazeli Jr.
23B. ADDRESS: 540 N. Linwood
23C. DATE SIGNED: 8/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/30/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): 4430 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Livingston Williams, M.D.
25. FUNERAL DIRECTOR, ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street

VS 150

61

077708

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 3- 077708 Registered No.

1. NAME OF DECEASED (Type or Print): LOUIS SCHLEICHER

2. DATE OF DEATH: 8-27-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

Length of stay in Baltimore: Yrs. 63 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2714 ORLEANS ST. 6-02

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 12-31-1885
9. AGE (In years last birthday): 63
If Under 1 Year: Months: 8 Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHECKER
10B. KIND OF BUSINESS OR INDUSTRY: Central R.R. Co.
11. BIRTHPLACE (State or foreign country): BALTIMORE MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LOUIS SCHLEICHER
14. MOTHER'S MAIDEN NAME: ELIZABETH JERSCHIED

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): UNKNOWN
16. SOCIAL SECURITY NO.: 705-10-9060
17. INFORMANT ADDRESS: 2714 Orleans Street - 24 Mrs. Gertrude Schleicher

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PERICARDIAL EFFUSION
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* AUGUST 25, 1949, *to* AUGUST 27, 1949, *that I last saw the deceased alive on* AUGUST 27, 1949, *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard K. Brack M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 8/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 8/30/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, Md
25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC. BALTIMORE - 13, MARYLAND

VS 150

90B

G77709

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6-10

G77709

Registered No.

1. NAME OF DECEASED (Type or Print) Edward Linton (EDWARD MOLPHIN LINTON)

2. DATE OF DEATH 8-27-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bal. Baltimore General Hospital

Length of stay in Baltimore 55 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1838 N. Wolfe St #13 8 0 5

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Dec. 14, 1873

9. AGE (In years last birthday) 75
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired.

10B. KIND OF BUSINESS OR INDUSTRY butcher

11. BIRTHPLACE (State or foreign country) VA.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Robert Lee Linton

14. MOTHER'S MAIDEN NAME not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT 1838 N. Wolfe Street-13 (Address)
Mrs. Bertie B. Linton

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolus

DUE TO

(B) postoperative prostatectomy.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II. Adenocarcinoma of rectum; Art. sclerotic cardiovascular dis, diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 8-22-49

19B. MAJOR FINDINGS OF OPERATION Hyperplasia of prostate gland.

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-19-49, 19__, *to* 8-27-49, 19__, *that I last saw the deceased alive on* 8-27-49, 19__, *and that death occurred at* 8.35A *m., from the causes and on the date stated above.*

23A. SIGNATURE Boone Leon Grant MD M. D.

23B. ADDRESS W.B.G.Hosp.

23C. DATE SIGNED 8-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial

24B. DATE 8/30/49

24C. NAME OF CEMETERY OR CREMATORY Baltimore cemetery

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949

REGISTRAR'S SIGNATURE Cemetington Williams, MD

25. FUNERAL DIRECTOR ADDRESS
HENRY SANDER & SONS, INC.
BALTIMORE - 13, MARYLAND

VS 150

467

077710

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 077710

1. NAME OF DECEASED (Type or Print): Charles Henry Wagner

2. DATE OF DEATH: August 27, 1949

3. PLACE OF DEATH: Baltimore City, Maryland 2517 Guilford Ave.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

Length of stay in Baltimore: 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2517 Guilford Avenue

12-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Aug. 6, 1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): glazier, retired 15 yrs.

10B. KIND OF BUSINESS OR INDUSTRY: Pittsburg Plate Glass Co.

11. BIRTHPLACE (State or foreign country): Carroll County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Samuel Wagner

14. MOTHER'S MAIDEN NAME: Caroline Sellman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Stella Kenly Wagner, ADDRESS: 2517 Guilford Ave.

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Several years.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none

19B. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 3, 1947 *to* Aug. 27, 1949, *that I last saw the deceased alive on* Aug. 27, 1949, *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Frank N. Orden. M. D.

23B. ADDRESS: 2701 N. Calvert St.

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 8 - 30 - 49

24C. NAME OF CEMETERY OR CREMATORY: Sepsutia

24D. LOCATION (City, town, or county) (State): Perrymans, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Place

Mahlon B. Mitchell 931

VS 150

077711 130762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6 Registered No. 077711

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Norman Mills.

2. DATE OF DEATH: August 25, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1017 Linden AVE.

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 8-30, 1890
9. AGE (In years last birthday): 58 YRS (If under 1 year: Months; If under 1 day: Days; If under 24 hours: Hours; Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paperhanger
10B. KIND OF BUSINESS OR INDUSTRY: ODD JOBS
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward J. Mills
14. MOTHER'S MAIDEN NAME: Clara Mills

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.

17. INFORMANT: Records Balto City Hospitals ADDRESS 4940 Eastern Ave

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Bronchogenic Carcinoma	6mos.
DUE TO (B)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 2, 1949 *to* August 25, 1949 *that I last saw the deceased alive on* August 25 1949, *and that death occurred at* 7.30A M., *from the causes and on the date stated above.*

23A. SIGNATURE H. S. Mayers M. D.
23B. ADDRESS 4940 Eastern Ave.
23C. DATE SIGNED 8-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/30/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemet.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: A. Halstead
ADDRESS: 916 Druid Hill Ave.

VS 150

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7712 — BALTIMORE CITY HEALTH DEPARTMENT — 443 — 077712

CERTIFICATE OF DEATH

Registered No.

RTH NO.

NAME OF DECEASED (Type or Print): CARRIE H. LAMB

2. DATE OF DEATH: Aug. 28, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Edgewood Nursing Home, 6000 Bellona Ave.

Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 203 E. Lake Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	March 23, 1864	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Lexington, Va.	

13. FATHER'S NAME: Peter Fischer

14. MOTHER'S MAIDEN NAME: Eve (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Roland H. Lamb	203 E. Lake Ave.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc., It means the disease, injury or complication which caused death.)

(A) Hypertension cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO

(B) General senile degeneration — 1 yr.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m/	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 26, 1949 *to* Aug 28, 1949 *that I last saw the deceased alive on* Aug 27, 1949, *and that death occurred at* 12:30 A m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Geo. D. Lyles, M. D.	432 N. Patterson Park Ave.	8/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/31/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 29 1949	Huntington Williams, M.D.C.	William Cook, Inc.,	1217 St. Paul St.

VS 150

937

B-131256

77713
IRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 77713

1. NAME OF DECEASED (Type or Print): Ada Wadsworth

2. DATE OF DEATH: Aug. 28-1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore: 9yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — Middle River
D. STREET ADDRESS (If rural, give location): 603 Wampler Road

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 3-1889
9. AGE (In years last birthday): 60 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Walter Hirshberger

14. MOTHER'S MAIDEN NAME: Elizabeth Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Records- ADDRESS: Baltimore City Hospitals 4940 Eastern Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) C.V.A. ?
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes Mellitus- Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 8-25-1949
19B. MAJOR FINDINGS OF OPERATION: Diabetic Gangrene of Extremities
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-22-4 , 1949 *to* 8-28- , 1949, *that I last saw the deceased alive on* 8-28- , 1949, *and that death occurred at* 2.18 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 8-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/30/49
24C. NAME OF CEMETERY OR CREMATORY: South Fork
24D. LOCATION (City, Town, or County) (State): South Fork Rd

DATE RECEIVED BY LOCAL REGISTRAR: AUG 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilson Cook Inc
ADDRESS: 1219 E. Fayette St

VS 150

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977714 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

91 Registered No. 977714

1. NAME OF DECEASED (Type or Print) Frank J. Hook

2. DATE OF DEATH August 27, 1949

3. PLACE OF DEATH: Baltimore City, Maryland 2101 Cold Spring Lane

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cold Spring Nursing Home

Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Balto.
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 5313 Cuthbert Ave 27 18

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH March 27 1866 | 9. AGE (In years last birthday) 83 | If under 1 Year: Months Days | If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | 10B. KIND OF BUSINESS OR INDUSTRY Farm | 11. BIRTHPLACE (State or foreign country) Mt Washington Balto Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Hook | 14. MOTHER'S MAIDEN NAME Josephine Boggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — | (If yes, give war or dates of service) — | 16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Raymond Feet ADDRESS 3929 Ridgewood Ave

CAUSE OF DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Squamous Cell Carcinoma — INTERVAL BETWEEN ONSET AND DEATH 1 yr.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1, 1949 to August 27 1949, that I last saw the deceased alive on Aug. 26, 1949, and that death occurred at 9a m., from the causes and on the date stated above.

23A. SIGNATURE Norman R Kleeman M. D. | 23B. ADDRESS 3803 Edmondson Ave | 23C. DATE SIGNED 8/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Sept 3/49 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet | 24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 29 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Loring Byers | ADDRESS 5005 Pk Heights Ave

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77715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077715

RTH NO.

NAME OF DECEASED (Type or Print): WILLIAM EDWARD RITTENHOUSE

2. DATE OF DEATH: Aug. 27, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF OSPITAL OR STITUTION (If not in hospital or institution, give street address or location): 3900 Duvall Ave.

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3900 Duvall Ave. 15-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Sept. 8, 1876	72 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditor

10B. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Hiram Rittenhouse

14. MOTHER'S MAIDEN NAME: Elizabeth Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Mary Rittenhouse — ADDRESS: 3900 Duvall St.

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min

DUE TO

(B) Coronary Arteriosclerosis — 2 yrs

DUE TO

(C) Generalized Arteriosclerosis — 10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral Hemorrhage — 9 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 19, 1937, *to* Aug 23, 1949, *that I last saw the deceased alive on* Aug 23, 1949, *and that death occurred at* 9:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 3403 Garrison Blvd.

23C. DATE SIGNED: Aug 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 8/30/49

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 30 1949

REGISTRAR'S SIGNATURE: [signature], M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150

94a

CERTIFICATE CORRECTED 9-22-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

7716 / 50 / G777716

Registered No.

STATE FILE NO.

NAME OF DECEASED (Type or Print) SELMA STROUSE

2. DATE OF DEATH Aug 28, 1949

PLACE OF DEATH: Baltimore City, Maryland Balto Md

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Private apt Balto Md

Length of stay in Baltimore 69 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Balto Md

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md 13-1

D. STREET ADDRESS (If rural, give location) Rivera Apt 5F Linden ave

5. SEX female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Nov 25 1879

9. AGE (In years last birthday) 69

If Under 1 Year: Months 9 Days 3

If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10B. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Balto Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob Mann

14. MOTHER'S MAIDEN NAME Mary Katzenstein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mr Abell Rosenberg Rivera apt ADDRESS Balto Md

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Paralysis agitans — INTERVAL BETWEEN ONSET AND DEATH: 23 years

DUE TO

(B) Generalized arteriosclerosis — 23 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 24 1926 to Aug 28 1949 that I last saw the deceased alive on Aug 27 1949 and that death occurred at 9.30 p m. from the causes and on the date stated above.

23A. SIGNATURE Louis P. Hamburger M. D.

23B. ADDRESS 1207 Eutaw Place

23C. DATE SIGNED Aug 29 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Aug 30 1949

24C. NAME OF CEMETERY OR CREMATORY Oheb Shalom

24D. LOCATION (City, town, or county) (State) O'Donnel St Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 30 1949

REGISTRAR'S SIGNATURE Williams, M.D.

25. FUNERAL DIRECTOR David Sondheim & Son ADDRESS 1902 Eutaw Place

VS 150

87c

7717 ✓ 77717

J1-131365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 ✓ Registered No. 77717

BIRTH NO.

NAME OF DECEASED (Type or Print): Elizabeth Vaughn

2. DATE OF DEATH: 8-27-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore: 50 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1228 Ashland Ave.-2

10-0 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
F	Negro	Wid.	March 17, 1865	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Leana Norman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. (ADDRESS)

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage

DUE TO

(B) Hypertensive cardiovascular Disease

DUE TO

(C) Arteriolar Nephrosclerosis ✓

Azotemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ~~ACCIDENT, SUICIDE~~ ~~HOMICIDE~~ (Specify Other Conditions): Head Injury
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): at home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1228 Ashland Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug. 21, 1949 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK No
21F. HOW DID INJURY OCCUR? Fell down staire

22. *I hereby certify that I attended the deceased from* 8-26-49, 19__, *to* Aug. 27, 1949 *that I last saw the deceased alive on* Aug. 27 1949, *and that death occurred at* 10.10PM *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 8-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 1 1949
24C. NAME OF CEMETERY OR CREMATORY: Mount Calvary Cem.
24D. LOCATION (City, town, or county) (State): A.A. County

DATE RECEIVED BY LOCAL REGISTRAR: AUG 30 1949
REGISTRAR'S SIGNATURE: Hunter Williams, M.D.
25. FUNERAL DIRECTOR: Lottie Gross
ADDRESS: 1408 ashland ave

VS 150

To be Approved by Medical Examiner

OVER

131a

7718 1458 ✓ 56 - 077718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BTH NO BC. 49-11458 Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Johns Allen
2. DATE OF DEATH: Aug 24, 1949
3. PLACE OF DEATH: Baltimore City, Maryland
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
   Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Md.
   B. COUNTY:
   C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-09
   D. STREET ADDRESS (If rural, give location): 2558 Garrett ave
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 6-5-49
9. AGE (In years last birthday): 3 mo. If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Brooks C. Allen
14. MOTHER'S MAIDEN NAME: Nettie Hanks
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pancreatic cystic fibrosis — Interval between onset and death: 3 mos.
DUE TO ? Biliary atresia — 3 mos.
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-18- 1949 *to* 8-24- 1949, *that I last saw the deceased alive on* 8-24 1949, *and that death occurred at* 11:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm H. Willbanks M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 8/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 8/31/49
24C. NAME OF CEMETERY OR CREMATORY: Farnham Baptist
24D. LOCATION (City, town, or county) (State): Dennings Va.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Jr.
ADDRESS: 129 St. Paul St

VS 150

1579

77719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

RTH NO.

Registered No. 77719

NAME OF DECEASED (Type or Print) JAMES A. EVANS

2. DATE OF DEATH AUG. 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 615 West Lexington St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 615 W. Lexington St. 402

Length of stay in Baltimore — Yrs. Mos. Days

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Male	White	Married	July 15, 1905	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Welder	CANNING MACHINERY A.K. Robbins	Mt. Vernon, Ky.	

13. FATHER'S NAME: James Evans

14. MOTHER'S MAIDEN NAME: Rhoda Porter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 400-07-6297

17. INFORMANT: Mrs Essie Evans — ADDRESS: 615 W. Lexington St.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pulmonary Tuberculosis — ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 20, 1949 *to* Aug 25, 1949 *that I last saw the deceased alive on* Aug 25, 1949 *and that death occurred at* 1:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Henry Glezerman M.D.	2532 N Fayette St	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/30/49	Mt Vernon	Mt Vernon, Ky

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Huntington Williams, M.D.	Wilson Funeral Dir	1217 E Pratt St

VS 150

12B

7720

TH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

151

Registered No. 077720

NAME OF DECEASED (Type or Print): LEONARD GEORGE WOLF

2. DATE OF DEATH: Aug. 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 27 N. Carey St. Good Samaritan Home

Length of stay in Baltimore: 63 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 619 N. Calvert St. 11-101

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	May 31, 1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sailor, retired		Germany	

13. FATHER'S NAME: John Wolf

14. MOTHER'S MAIDEN NAME: Elizabeth Englehardt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mary Harrison	2543 McHenry St.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of stomach

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 25 Aug, 1949 *to* 29 Aug, 1949, *that I last saw the deceased alive on* 29 Aug., 1949 *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Emil F. Henning, Jr. M. D.	4580 Edmondson Ave	29 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/1/49	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Huntington Williams, M.D.	William Cook, Inc.,	1217 St. Paul St.

VS 150

46B

7721

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 7721

1. NAME OF DECEASED (Type or Print): CHARLES E. NELSON

2. DATE OF DEATH: August 29, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1669 Darley Avenue

Length of stay in Baltimore: Yrs. Mos. - Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1669 Darley Avenue

5. SEX: Male
6. COLOR OR RACE: White
7. ~~SINGLE~~. MARRIED. ~~WIDOWED, DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: 4/7/1880
9. AGE (In years last birthday): 70 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Machinist
10B. KIND OF BUSINESS OR INDUSTRY: Pa. R.R.

11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry A. Nelson
14. MOTHER'S MAIDEN NAME: Mollie Lorenna Kavanah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:

17. INFORMANT: Elsie Nelson | ADDRESS: 1669 Darley Ave

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: C. P. Sabrinski M.D.
23B. CHIEF MEDICAL EXAMINER ..... ASSISTANT MEDICAL EXAMINER ..... MEDICAL INVESTIGATOR X
23C. DATE SIGNED: 8-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/1/49
24C. NAME OF CEMETERY OR CREMATORY: Morland Park
24D. LOCATION (City, town, or county) (State): Parkville Md.

DATE RECEIVED BY REGISTRAR: AUG 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook Inc. | ADDRESS: 1217 St. Paul St.

VS 151

93D

ROSENBAM Vol. 3

7722

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

RTH NO.

Registered No. 077722

NAME OF DECEASED (Type or Print): Russell Rosenbaum

2. DATE OF DEATH: 8/27/49

PLACE OF DEATH: Baltimore City, Maryland Mercy Hosp

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

Length of stay in Baltimore: 11 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3402 Hackney Road 13-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	March 3, 1935	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter Rosenbaum

14. MOTHER'S MAIDEN NAME: Mildred Seitz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: [illegible] ADDRESS

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 22 days

DUE TO

(B) Rheumatic pneumonia — 5 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 9, 1949, *to* 8/27, 1949, *that I last saw the deceased alive on* 8/27, 1949, *and that death occurred at* 10 30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Richard Franel M. D.	Mercy Hosp	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 30 49	Druid Ridge	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Lexington Williams, M.D.	Frank H Seitz	814 W 36 St.

VS 150

581

777/23

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 777723

1. NAME OF DECEASED (Type or Print): Clara Hudson

2. DATE OF DEATH: Aug 28-49

PLACE OF DEATH: Baltimore City, Maryland / 1004 Creek St

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ——

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 1004 Creek St. B. COUNTY: Balto

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

D. STREET ADDRESS (If rural, give location): 1004 Creek St 23 01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colrd	Widow	1894	55				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at Home

10B. KIND OF BUSINESS OR INDUSTRY: ——

11. BIRTHPLACE (State or foreign country): Balto

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Seemore

14. MOTHER'S MAIDEN NAME: Cora ——

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —— (If yes, give war or dates of service): ——

16. SOCIAL SECURITY NO.

17. INFORMANT: Corine Campbell ADDRESS: 616 Wilson

CAUSE OF DEATH

18.

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

(B) Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 19, 1949 *to* Aug 28, 1949, *that I last saw the deceased alive on* Aug 27, 1949 *and that death occurred at* 5:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John C. Gaines M. D. | 23B. ADDRESS: 507 W. Hamburg St | 23C. DATE SIGNED: 8/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Aug 31-49 | 24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn | 24D. LOCATION (City, town, or county) (State): Balto

DATE RECEIVED BY LOCAL REGISTRAR: AUG 30 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, MD | 25. FUNERAL DIRECTOR: James A. Hayes | ADDRESS: 638 N. Gilmor St

VS 150

937

777?4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 34 777?4

RTH NO. Negro

NAME OF DECEASED (Type or Print) James M. Butler

2. DATE OF DEATH Aug 29 1949

PLACE OF DEATH: Baltimore City, Maryland 1906 McCulloh

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md B. COUNTY Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1906 McCulloh 14-03

Length of stay in Baltimore Life — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	negro	married	Sept 27 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping clerk
10B. KIND OF BUSINESS OR INDUSTRY: Book Publishing
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: James T. Butler
14. MOTHER'S MAIDEN NAME: Hannah F. Henderson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lillie Butler ADDRESS: 1906 McCulloh

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio Vascular — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO
(B) Cardiac Asthma
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 29 1949 *to* Aug 29 1949, *that I last saw the deceased alive on* Aug 29, 1949, *and that death occurred at* 4:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: J. Edward Fisher M. D.
23B. ADDRESS: 1612 Monument
23C. DATE SIGNED: 8-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): B.
24B. DATE: 9-1-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): A. A. Co. — Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 30 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: Samuel W. Sullivan Jr.
ADDRESS: 1011 N. Arlington Ave 21

VS 150

77/25 FL 130647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 0777725

BIRTH NO.

1. NAME OF DECEASED (Type or Print)	Anna Margaret Hasson
2. DATE OF DEATH	8-28-49
PLACE OF DEATH:	Baltimore City, Maryland
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	Baltimore City Hospitals 4940 Eastern Ave.
Length of stay in Baltimore	25 yrs. (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Md.
B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	921 Lemmon St. 18 93
5. SEX	F
6. COLOR OR RACE	W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	Sep.
8. DATE OF BIRTH	July 14, 1888 ?
9. AGE (In years last birthday)	61 ?
If Under 1 Year: Months / Days	
If Under 24 Hours: Hours / Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	House Work
10B. KIND OF BUSINESS OR INDUSTRY	at Home
11. BIRTHPLACE (State or foreign country)	W. Va.
12. CITIZEN OF WHAT COUNTRY?	U S A
13. FATHER'S NAME	Charles C. Jones
14. MOTHER'S MAIDEN NAME	Margaret A. Horn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS	B. C. H. Records, 4940 Eastern Ave.

CAUSE OF DEATH

18.

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

W. J. McCafferty M.D.

for: C.J.Lubinski, M. D.

CHIEF OR ASST. MEDICAL EXAMINER.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	8-2-49
19B. MAJOR FINDINGS OF OPERATION	Reduction of fracture- Insertion of Blount plate
20. AUTOPSY?	YES ☒ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	Fracture of L. Hip
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	at home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	921 Lemmon St
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	7-28-49 m.
21E. INJURY OCCURRED	WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?	Had a dizzy spell and fell down

22. *I hereby certify that I attended the deceased from* July 28, 1949 *to* Aug 28, 1949, *that I last saw the deceased alive on* Aug. 28, 1949, *and that death occurred at* 10.15 PM *from the causes and on the date stated above.*

23A. SIGNATURE	M. D.	
23B. ADDRESS	4940 Eastern Ave.	
23C. DATE SIGNED	8-29-49	
24A. BURIAL, CREMATION, REMOVAL (Specify)	Burial	
24B. DATE	8/31/49	
24C. NAME OF CEMETERY OR CREMATORY	London Park Cem.	
24D. LOCATION (City, town, or county) (State)	3801 Frederick Ave	
DATE RECEIVED BY LOCAL REGISTRAR	AUG 30 1949	
REGISTRAR'S SIGNATURE	Hunter for Williams, M.D.	
25. FUNERAL DIRECTOR	John J. Lowans Son	
ADDRESS	Collins Ave.	

To be approved by Medical Examiner

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7726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

STH NO. 7726 — Registered No. 7726

1. NAME OF DECEASED (Type or Print): CATHERINE MARY MANSFIELD

2. DATE OF DEATH: Aug. 29, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1818 N. Regester Street

Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1818 N. Regester Street

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Sept. 1, 1866
9. AGE (In years last birthday): 82 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Michael Flynn
14. MOTHER'S MAIDEN NAME: Mary ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Margaret Gross 1818 N. Regester St. 13

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — Interval: 1 hr.
DUE TO
(B) Arteriosclerotic heart disease — Interval: ? yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/29/, 1949, *to* 8/29/, 1949, *that I last saw the deceased alive on* 8/29/, 1949, *and that death occurred at* 3:35 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1737 E. North Ave
23C. DATE SIGNED: 8/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 9/1/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 30 1949
REGISTRAR'S SIGNATURE: [signature] for Baltimore, Md.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MARYLAND

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9 Registered No. 077727

1. NAME OF DECEASED (Type or Print): Pauline Robinson

2. DATE OF DEATH: AUG 27 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): John Hopkins Hosp.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 1622 McCulloh St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	sep.	10-25-03	45 46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Presser-Laundry
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): S.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Willie Timmons

14. MOTHER'S MAIDEN NAME: Millie Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.:

17. INFORMANT: Catherine Turner ADDRESS: 1622 McCulloh St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Glioblastoma multiforme
DUE TO
(B)
DUE TO Respiratory failure
(C) Increased intracranial pressure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: 8-26-49
19B. MAJOR FINDINGS OF OPERATION: Glioblastoma Multiforme - R. temporal lobe
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-24- 1949 to 8-27, 1949 that I last saw the deceased alive on 8-27- 1949 and that death occurred at 2.05 A m., from the causes and on the date stated above.

23A. SIGNATURE: J. L. McLellan M. D.
23B. ADDRESS:
23C. DATE SIGNED: 8/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 31, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS: 1631 Druid Hill Ave.

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72-250890 CERTIFICATE CORRECTED 9-30-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 96-9 077728

BIRTH NO. _____ Registered No. _____

1. NAME OF DECEASED (Type or Print) Henry Bruins, Jr. 8 0 8 6

2. DATE OF DEATH 8/29/49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1947 Perl MAN, Place 8 47

5. SEX Mail
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S.
8. DATE OF BIRTH Sept 7th 1930
9. AGE (In years last birthday) 19 — If under 1 Year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henrey Bruins
14. MOTHER'S MAIDEN NAME Florence Lacy Lacey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Convulsions — Interval between onset and death: 24 hours.
DUE TO Uraemia
(B) Bilateral Pyelonephritis — 24 hours
DUE TO Bilateral Pyelectasis
(C) Lower Urinary Obstruction — 4 years
Due to Fractured Pelvis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-28-, 1949 to 8-29-, 1949 that I last saw the deceased alive on 8-29-, 1949, and that death occurred at 3 a m., from the causes and on the date stated above.

23A. SIGNATURE [signature] M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 8/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept 1st 1949
24C. NAME OF CEMETERY OR CREMATORY Meadow Ridge
24D. LOCATION (City, town, or county) Washington Blvd (State)

DATE RECEIVED BY LOCAL REGISTRAR 8-30-1949
REGISTRAR'S SIGNATURE [signature] Baltimore, Md.
25. FUNERAL DIRECTOR Leo G. Leach ADDRESS 1705 N. Patterson Park ave

VS 150

Dr. J. deKlerk

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7729 — 1 — 077729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

7729 — Registered No.

TH NO.

NAME OF DECEASED (Type or Print) **Martha Jeanette Shaull**

2. DATE OF DEATH **Aug. 29/49**

PLACE OF DEATH: **Baltimore City, Maryland** **Md.**

FULL NAME OF SPITAL OR STITUTION (If not in hospital or institution, give street address or location) **501 Allendale t.**

Length of stay in Baltimore **25 yrs.** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **501 Allendale St.** 20-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	**White**	**Single**	**June 7,1878**	**71**				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		**W. Va.**	

13. FATHER'S NAME **John J. Shaulk**

14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, or no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mrs. Edwin Fox, 627 N. Augusta Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cerebral Hemorrhage** — INTERVAL BETWEEN ONSET AND DEATH: **2 wks**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Arteriosclerotic Cardio Vascular Disease** — **5 yrs+**

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **Jan** 19**44** *to* **8/29** 19**49** *that I last saw the deceased alive on* **8/29** 19**49** *and that death occurred at* **3 30/60** *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thos E Ross M. D.	**3629 Edmondson Ave**	**8/29/49**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	**Aug. 31/49**	**Mt. Olivet, 2930 Frederick Rd. Balto. Md.**	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Huntington Williams, M.D.	**Harry A. Dintaman**	**3601 Edmondson Ave.**

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

Registered No. 47730

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John C. Holder (c)

2. DATE OF DEATH 8-28-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2110 Eagle St.

Length of stay in Baltimore Life (Yrs. Mos. Days)

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH Aug. 16, 1893
9. AGE (In years last birthday) 56
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEPARATOR
10B. KIND OF BUSINESS OR INDUSTRY Calvert Metal
BRUSH BRNDS

11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Holder

14. MOTHER'S MAIDEN NAME Mary C. -------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216 03 1139

17. INFORMANT (sister) ADDRESS Mrs. George Carson 2110 Eagle St.

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Colecum
DUE TO (B) metastasis to liver, lung and retroperitoneal nodes
(B) Acute pulmonary edema -
DUE TO (C) Rt hydrothorax
(C) Chronic arteriolar nephro-sclerosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 28 1949 *to* August 28, 1949, *that I last saw the deceased alive on* August 28 1949, *and that death occurred at* 5:20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Leonard Tucker M. D.
23B. ADDRESS West Baltimore Genl Hosp.
23C. DATE SIGNED 8-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE Sept. 1/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park, 3801 Frederick Rd.
24D. LOCATION (City, town or county) (State) Balto. 29, Md.

DATE RECEIVED BY LOCAL REGISTRAR AUG 30 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Harry N. Lutz
ADDRESS 4101 Edmondson Ave

VS 150

Leonard Tucker

46E

7731 — BALTIMORE CITY HEALTH DEPARTMENT — 077731

CERTIFICATE OF DEATH

TH NO. — Registered No.

NAME OF DECEASED (Type or Print): HARRIET A. SCHROEDER

2. DATE OF DEATH: 8/29/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR STITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSP

Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN: Balto. (If outside corporate limits, write RURAL and give township) 11-04
D. STREET ADDRESS (If rural, give location): 241 W. LANVALE ST

5. SEX	6. COLOR OR RACE	7. SINGLE, ~~MARRIED~~, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Single	Mar 20, 1880	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nurse		Md.	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Self.	

CAUSE OF DEATH

18.

I **DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Arrest — DUE TO

(B) arteriosclerotic CVD — DUE TO

(C) — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

INTERVAL BETWEEN ONSET AND DEATH

II **OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month), (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/1, 19 49 *to* 8/29, 19 49, *that I last saw the deceased alive on* 8/29, 19 49 *and that death occurred at* 7 30 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nicholas Wallis M. D.	Univ. Hosp	8/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	Aug. 31/49	Loudon Pk.	3801 Frederick Ave Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Huntington Williams, M.D.	Henry H. Wiltse	4101 Edmondson Ave

VS 150

937

77132
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13.° 077732
Registered No.

1. NAME OF DECEASED (Type or Print) Frank Gamble N-805.0
2. DATE OF DEATH Aug 28/49
3. PLACE OF DEATH: Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Dundalk
D. STREET ADDRESS (If rural, give location) 537 New Pittsburg Ave
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
Length of stay in Baltimore Yrs. Mos. Days
5. SEX male
6. COLOR OR RACE Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Oct 13, 1904
9. AGE (In years last birthday) 44 45 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker
10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.
11. BIRTHPLACE (State or foreign country) Farmville Va
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Jno Gamble
14. MOTHER'S MAIDEN NAME Rosa Jefferson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Eleanor Gamble ADDRESS 537 New Pittsburg Ave

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture. Dislocation Cervical
DUE TO
(B) Shock
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 537 New Pittsburg Ave. Turners Station
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY August 27, 1949 1:20 a.m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Balto. Co., Md. Thrown from steps during altercation

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒ undetermined ☐.*

23A. SIGNATURE Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED 29 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal
24B. DATE Sept 30
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State) Farmville Va

DATE RECEIVED BY LOCAL REGISTRAR AUG 30 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mrs Roberts Edelen Sons ADDRESS 168 N 29th St

S 151

7733 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 777733

NAME OF DECEASED (Type or Print) Elizabeth P. Webb

2. DATE OF DEATH 8/28/49

PLACE OF DEATH: Baltimore City, Maryland 1752 Park Ave.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1752 Park Ave.

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 1752 Park Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1752 Park Ave. 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	WIDOWED	March 21, 1859	90		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George W. Webb

14. MOTHER'S MAIDEN NAME Elizabeth Peach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Elizabeth Webb ADDRESS 1752 Park Ave.

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH short time

DUE TO

(B) Chronic Myocarditis — several years.

DUE TO

(C) Old age.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No.	NONE	

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July. 10. 19 49, *to* Aug. 28, 19 49, *that I last saw the deceased alive on* Aug. 29. 19 49, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert C. Blake M. D.	422 Med. Arts Bldg	8-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/31/49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Turnbridge Williams, M.D.	M. Faherty Sons	1827 W. North Ave

VS 150

937

~~77734~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

Registered No. 077734

RTH NO.

1. NAME OF DECEASED (Type or Print) Jessie F Flint

2. DATE OF DEATH 8/28/49

3. PLACE OF DEATH: Baltimore City, Maryland Mercy Hosp

FULL NAME OF HOSPITAL OR STITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

Length of stay in Baltimore 33 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1107 Orleans St 5-02

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widower
8. DATE OF BIRTH June 6, 1894
9. AGE (In years last birthday) 45 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired) Cook
10B. KIND OF BUSINESS OR INDUSTRY Fish factory
11. BIRTHPLACE (State or foreign country) Canton Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James F Flint
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Richard Evans ADDRESS 1107 Orleans St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension Cardiac renal Uremia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/28, 1949 *to* 8/28, 1949, *that I last saw the deceased alive on* 8/28/, 1949, *and that death occurred at* 8:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE C. Richard Evans M. D.
23B. ADDRESS Mercy Hosp
23C. DATE SIGNED 8/29/49

24A. BURIAL, CREMATION OR REMOVAL (Specify) Burial
24B. DATE Aug. 30-49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 30 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Elroy O. Wilson
ADDRESS 1100 Bramty Wy

VS 150

937

777735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 777735

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Barbara DeGele

2. DATE OF DEATH Aug. 28/49

3. PLACE OF DEATH: Baltimore City, Maryland 3317 Devonshire Drive

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore 69yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE
b. COUNTY
3317 Devonshire Drive 27-20

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balto. Md.

d. STREET ADDRESS (If rural, give location)
3317 Devonshire Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Widowed	Sept. 17, 1863	85				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
--	---	Germany	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
--	- -	--

17. INFORMANT: Mr. Geo. DeGele — ADDRESS: 435 N. Bouldin St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Generalized arteriosclerosis — 20+ yrs.

DUE TO

(C) Bronchopneumonia — 2 days?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Heart Dis. — ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8 pm 8/28, 1949, to 11 45 pm 8/28, 1949, *that I last saw the deceased alive on* 8/28, 1949, *and that death occurred at* 11 45 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis H. Cohen M. D.	590 Park Heights Ave	8/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 1/49	Schwartz's Cem	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Huntington Williams, M.D.	Philip Henry & Son	2024 Orleans St.

937

VS 150

7736 RTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077736

NAME OF DECEASED (Type or Print) JOHN C. SCHLEUPNER

2. DATE OF DEATH 8/29/49

PLACE OF DEATH: Baltimore City, Maryland 1510 N. MONTFORD AVE

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1510 N. MONTFORD AVE. 8-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
MALE	WHITE	MARRIED	JUNE 29 1894	55				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ASS'T MANAGER	Monumental Life INSURANCE	Baltimore, Md.	

13. FATHER'S NAME: George Schleupner

14. MOTHER'S MAIDEN NAME: Mary Fleichman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
World War I	212-01-8118	Ethel C. Schleupner	1510 N. Montford Ave.

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 7 weeks.

DUE TO

(B) Chron. Coronary sclerosis — unknown

DUE TO

(C) Arteriosclerosis — unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 0

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 18 Sept, 1948, *to* 29 Aug, 1949 *that I last saw the deceased alive on* 29 Aug 19 49, *and that death occurred at* 11.15 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Howard Poor M.D.	1513 N. Milton Ave.	Aug 30, 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-1-49	Holy Redeemer	Baltimore - Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Huntington Williams, M.D.	John C. Miller Inc.	2435 E. Oliver St.

VS 150

94a

CERTIFICATE CORRECTED 8-31-49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

077737 — 077737

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): SAMUEL EDWIN HACKER

2. DATE OF DEATH: August 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2007 E. 32nd Street

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2007 E. 32nd Street 9-06

SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 25, 1872
9. AGE (In years last birthday): 77 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10B. KIND OF BUSINESS OR INDUSTRY: Airplane Business
11. BIRTHPLACE (State or foreign country): Fayetteville, Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edwin Hacker
14. MOTHER'S MAIDEN NAME: Anna Anita Colby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: C. Colton (Mrs. Sarah Colter) ADDRESS: 2007 E. 32nd St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: C. A. Gubrinski M.D.
23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR: X
23C. DATE SIGNED: 8-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8/31/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 151

937

977738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 977738

BIRTH NO.

NAME OF DECEASED (Type or Print): John "Joseph" Caruso "Joseph"

2. DATE OF DEATH: 8-26-49

PLACE OF DEATH: Baltimore City, Maryland Sinai Hospital

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 3112 W. Garrison Ave. Baltimore
D. STREET ADDRESS (If rural, give location): 3112 W. Garrison Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	June 11, 1920	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Butcher	Food Market	Jenners, Pa.	USA

13. FATHER'S NAME: Andrew Caruso

14. MOTHER'S MAIDEN NAME: Charlotte Giardina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW2	089-05-6684	Mrs. Georgia Caruso	3112 W. Garrison Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Thrombosis of BASILAR ART.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
BILAT Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-21 19 49 *to* 8-26 19 49 *that I last saw the deceased alive on* 8-26 19 49 *and that death occurred at* 9.25 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leonard Korn M. D.	Sinai Hosp	8-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/30/49	Lorraine	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Lurington Williams, M.D	WM. J. TICKNER & SONS INC.	North & Pa. Aves. Balto. 17, Md.

VS 150

83B

977739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

37

Registered No. 977739

RTH NO.

NAME OF DECEASED (Type or Print) ANNE ELIZABETH JENNINGS

2. DATE OF DEATH 8-28-49

PLACE OF DEATH: Baltimore City, Maryland Union memorial Hosp

FULL NAME OF HOSPITAL OR STITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 10
D. STREET ADDRESS (If rural, give location) 5512 Roland ave 27-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	white	Single	Sept 17 1927	21				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher

10B. KIND OF BUSINESS OR INDUSTRY Teacher - Cornell University

11. BIRTHPLACE (State or foreign country) Balto Md.

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME Frank L Jennings M.D.

14. MOTHER'S MAIDEN NAME Hazel Baer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No, yes or unknown) Known (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Dr. Frank L. Jennings ADDRESS 5512 Roland Ave.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Craniotomy + injection of air for ventriculography — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

DUE TO

(B) Suspected Respiratory arrest — 1 hr.

DUE TO

(C) Suspected brain tumor (occ) — 1 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-28-49	Suspicious area of possible tumor formation	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-27, 1949 *to* 8-28, 1949, *that I last saw the deceased alive on* 8-28, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	Union Memorial Hospital	8-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/31/49	Greenmount Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

567

077740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077740

TH NO.

1. NAME OF DECEASED (Type or Print): CHARLES H. MELSON

2. DATE OF DEATH: Aug. 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 104 W. University Pkwy.

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 104 W. University Pkwy.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Divorced	Oct. 25, 1853	95 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
salesman	Dry Goods	Accomac Court House, Va.	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO

17. INFORMANT: Mr. John M. Mackenzie — ADDRESS: 104 W. University Pkwy.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Arterio-Sclerosis-generalized — years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Carcinoma of the Prostate — 2 years +

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August, 1947 *to* August 22, 1949, *that I last saw the deceased alive on* Aug. 24, 1949, *and that death occurred at* 12:22 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry W. Hansan M. D.	20 E. Preston St.	8/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/31/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Curtis Worthington Holbrook, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

51B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 Registered No. 077741

077741
TH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM MILES HOWARD BALLANTYNE

2. DATE OF DEATH Aug. 29, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Rural
D. STREET ADDRESS (If rural, give location) 5510 Windsor Mill Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	M.	9-25-1886.	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer

10B. KIND OF BUSINESS OR INDUSTRY Pa. Water & Power Co.

11. BIRTHPLACE (State or foreign country) Scotland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Ballantyne dec'd

14. MOTHER'S MAIDEN NAME Elizabeth Jardine dec'd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Gabrielle Slator ADDRESS 5510 Windsor Mill Rd.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ADENO CARCINOMA OF RECTUM

DUE TO (B) MULTIPLE METASTASIS TO LIVER

DUE TO (C) PULMONARY INFARCT LEFT LOWER LOBE - INFARCT RT. VENTRICLE

DUE TO PERICARDITIS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 6/30/49

19B. MAJOR FINDINGS OF OPERATION ADENOCARCINOMA RECTUM & METASTASIS

20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 8/29, 1949, *that I last saw the deceased alive on* 8/29, 1949 *and that death occurred at* 6:45 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE John H. Shaw M. D.

23B. ADDRESS 10 E. Lanvale St.

23C. DATE SIGNED 8/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal

24B. DATE 8/31/49

24C. NAME OF CEMETERY OR CREMATORY Bethesda

24D. LOCATION (City, Town, or County) (State) Bethesda, Pa.

DATE RECEIVED BY LOCAL REGISTRAR AUG 30 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm. J. TICKNER & SONS ADDRESS Balto., Md.

VS 150

467

077742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

077742 Registered No.

RTH NO.

1. NAME OF DECEASED (Type or Print) MARION LEE BROWN

2. DATE OF DEATH Aug. 28, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2430 Brambleton Rd.

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 2430 Brambleton Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
ale	white	Married	Jan. 18, 1892	57 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Capt. Guards	U.S.Coast Guard	Forest Hill, Md.	

13. FATHER'S NAME: Edward Marion Brown

14. MOTHER'S MAIDEN NAME: Emma Lee Smithson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	World #1	213-05-7847	Mrs. Louise O. Brown	2430 Brambleton Rd

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Interstitial Nephritis	1 year
DUE TO (B)	Chronic Cardiovascular Renal disease	3 months
DUE TO (C)	Uremia Coma	1 day
	Uremic Convulsions	2 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 1, 1949 *to* Aug 25, 1949 *that I last saw the deceased alive on* Aug 25, 1949, *and that death occurred at* 5.15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sherman Wants M. D.	2601 Manhattan Ave	8/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/31/49	Centre Cem.	Forest Hill, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

131a

743 BALTIMORE CITY HEALTH DEPARTMENT Vol 1 — 077743

TH NO. **CERTIFICATE OF DEATH** Registered No.

NAME OF DECEASED (Type or Print) JENNIE MATULEWICZ

2. DATE OF DEATH August 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1526 W. Lombard St.

Length of stay in Baltimore 60 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1526 W. Lombard St. 19-23

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Dec. 29, 1863	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home Duties	Home	Poland	

13. FATHER'S NAME: Stanley Nagnornowski

14. MOTHER'S MAIDEN NAME: Anna Cornovich

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Miss Anna Matulewicz	

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 19 hours

DUE TO

(B) Arteriosclerotic Cardiovascular Disease — 20 years

DUE TO

(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None	None	None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* August 22, 1949, *to* Aug 29, 1949, *that I last saw the deceased alive on* Aug 29, 1949, *and that death occurred at* 11:55 Am., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph L. Bird, M. D.	4602 Northwood Drive	Aug 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 1, 1949	New Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Huntington Williams, M.D.	Fred H. Wolf	1913 Baltimore St

VS 150

931

077744

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 31

077744

STATE NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Laura Butler.

2. DATE OF DEATH: Aug. 28, 1949

3. PLACE OF DEATH: Baltimore City, Maryland 403 N. Schroeder

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 403 N. Schroeder

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 403 N. Schroeder St B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 403 N. Schroeder St 18-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	C	Widow	June 30 1879	70 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): A. A. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eli Thompson.
14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.

17. INFORMANT: Jessie Green. ADDRESS: 818 McHenry Ave.

CAUSE OF DEATH

16. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage. — Interval between onset and death: 4 days

DUE TO

(B) Hypertension & arteriosclerosis 7 yr.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

none.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1942 *to* Aug 31, 1949, *that I last saw the deceased alive on* Aug 28, 1949, *and that death occurred at* 12 Noon *from the causes and on the date stated above.*

23A. SIGNATURE: Jas. L. Julian Jr. M. D.
23B. ADDRESS: 511 N. Schroeder St Balto
23C. DATE SIGNED: 8/30/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 8-31-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Katie R Williams
ADDRESS: 322 N. Schroeder St

VS 150

83a

077745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

077745

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Joseph Henderson.

2. DATE OF DEATH Aug. 25, 1949.

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 805 N. Mount St.

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 805 N. Mount St.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16 C 2
D. STREET ADDRESS (If rural, give location) 805 N. Mount St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
male	C	Widower	June 23, 1886	63				

10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Catonsville, Md.	U.S.A.

13. FATHER'S NAME Joseph Henderson

14. MOTHER'S MAIDEN NAME Burton.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT Robert Henderson. ADDRESS 805 N. Mount St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-renal-Vascular disease. — INTERVAL BETWEEN ONSET AND DEATH: 3 years.

DUE TO

(B)

DUE TO

(C) Hemiplegia — 3 years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 10, 1949 *to* Aug. 25, 1949, *that I last saw the deceased alive on* Aug. 27, 1949, *and that death occurred at* 7 45 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
George Page M. D.	816 N. Mount St	8-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-1-1949	Western Star	Catonsville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Huntington Williams, M.D.	Wm. Katie R. Williams & Schroeder	322

VS 150

131a

BTH NO. 977746

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

49 ✓ Registered No. 977746

1. NAME OF DECEASED (Type or Print) Albert Swinson

2. DATE OF DEATH 8-29-49

PLACE OF DEATH: Baltimore City, Maryland Provident Hospital

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 320 N. Pearl St. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md.
D. STREET ADDRESS (If rural, give location) 320 N. Pearl St. 4-0 ✓

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Single	March 17, 1917	32		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	MFG. Box Co.	Snowhill, N.C	

13. FATHER'S NAME John Swinson.

14. MOTHER'S MAIDEN NAME Minnie Atkinson.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	

17. INFORMANT Mattie Swinson. ADDRESS 1615 Madison Ave

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Probably Virus Pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 8-28, 1949, to 8-29, 1949 that I last saw the deceased alive on 8/29, 1949, and that death occurred at 7:00 P.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Irving W. Sieger M.D.	Provident Hosp.	8/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	8-31-49	Farmville N.C	Farmville N.C

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Tunstall Williams, M.D.	Wm Kahe R. Williams	1502 W. Lafayette St.

VS 150

109a

077747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. 077747

TH NO.

NAME OF DECEASED (or Print) Louise S. DeMar

2. DATE OF DEATH Aug. 27, 1949.

PLACE OF DEATH: Baltimore City, Maryland 121 S Stockton St

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 121 S. Stockton St

Length of stay in Baltimore Yrs. Mos. Days

3. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
121 S. Stockton St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md. 18-02
D. STREET ADDRESS (If rural, give location) 121 S. Stockton St.

4. SEX	5. COLOR OR RACE	6. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	7. DATE OF BIRTH	8. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	C	Widow	Aug 19 1890	59		

9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Washington, D. C.	U.S.A.

13. FATHER'S NAME Robert Spottswood

14. MOTHER'S MAIDEN NAME Maria Wallen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT Alberta Freeman ADDRESS 900 W Lexington St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C) Coronary Failure - Cardiac Hypertrophy.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 26, 19 49 *to* Aug 27, 19 49 *that I last saw the deceased alive on* Aug 26 19 49 *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Simpson H. Carter, Jr. M. D.	1515 Pennsylvania Ave	8/30/49

24A. BURIAL, CREMATION OR REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	8-31-49	Mt. Auburn Cem.	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Huntington Williams, M.D.	Mrs. Katie R. Williams & Sons	392

VS 150

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077748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077748

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Dorothy Colbert

2. DATE OF DEATH August 28, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

d. STREET ADDRESS (If rural, give location) 610 N. Gilmor Ave. 16-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	C	Married	7-31-1889	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b. KIND OF BUSINESS OR INDUSTRY DAY WORKER

11. BIRTHPLACE (State or foreign country) Govans, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Henry Short

14. MOTHER'S MAIDEN NAME Sarah Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Bernadiet Dutton ADDRESS 532 N. Carrollton Ave

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Arteriosclerotic heart disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE: WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23a. SIGNATURE	23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23c. DATE SIGNED
George G. Merrill M.D.		August 29, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-1-49	New Cathedral Cem.	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Territa Lee Williams, M.D.	Wm Ralph R Williams	2202 W. Lafayette Ave

S 151

937

X ✓

77749 — BALTIMORE CITY HEALTH DEPARTMENT — 077749

CERTIFICATE OF DEATH

TH NO. — Registered No.

NAME OF DECEASED (Type or Print): James P. Brown

2. DATE OF DEATH: AUG 27 1949

PLACE OF DEATH: Baltimore City, Maryland — Osler 2

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore: 6 weeks (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bradshaw
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	colored	married	10-25-97	51				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trackman
10B. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Md. (Bradshaw)
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Brown
14. MOTHER'S MAIDEN NAME: Bebe Brown Pinkney
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 705-09-7424
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: ? 4 mos.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-7-, 1949 *to* 8-27-, 1949 *that I last saw the deceased alive on* 8-27-, 1949 *and that death occurred at* 11:15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Robert C. Hantmann M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 8/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Aug 31, 1949
24C. NAME OF CEMETERY OR CREMATORY: Asbury
24D. LOCATION (City, town, or county) (State): Lorely, Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Howard E. McComas & Son
55E Abingdon. Md.

VS 150

077750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

760

077750

Registered No.

TH NO.

NAME OF DECEASED (Type or Print)
Catherine Getek

2. DATE OF DEATH Aug. 28-1949

PLACE OF DEATH:
Baltimore City, Maryland 3000 Dillon St.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Home

Length of stay in Baltimore 51 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore 24 (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 3000 Dillon St. 1-01

SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 1875
9. AGE (In years last birthday): 74 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Michael Barus

14. MOTHER'S MAIDEN NAME: Regina Fiol

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Paul Trzeciak ADDRESS: 717 S. Lakewood Ave.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetic gangrene-Rt foot 5 days

DUE TO

(B) Diabetes mellitus

DUE TO

Generalized arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/1 19 49 *to* 8/28, 19 49 *that I last saw the deceased alive on* 8/30, 19 49 *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Stanley B. Klyanowicz M. D.

23B. ADDRESS: 3500 Edmondson Ave

23C. DATE SIGNED: 8/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Sept 1-1949

24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus

24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 30 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: George A. Weber ADDRESS: 705-9 Penn at

VS 150

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7751 2001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 10 Registered No. 077751

CITY NO.

1. NAME OF DECEASED (Type or Print) Stanley Lemiesz

2. DATE OF DEATH AUG 30 1949

3. PLACE OF DEATH: Baltimore City, Maryland Osler - 16

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 725 S. Bond, St 2-03

5. SEX male | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH ?-?-1889 | 9. AGE (If years last birthday) 60 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | 10B. KIND OF BUSINESS OR INDUSTRY BREWERY

11. BIRTHPLACE (State or foreign country) Poland | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ? | 14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-10-0951

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) gastro-intestinal bleeding — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO

(B) peptic ulcer
DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-26-, 1949 *to* 8-30-, 1949 *that I last saw the deceased alive on* 8-30-, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE Philip J. Hagler M. D. | 23B. ADDRESS JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE SEPT 2-1949 | 24C. NAME OF CEMETERY OR CREMATORY Holy Cross Brooklyn | 24D. LOCATION (City, town, or county) (State) Arundel Co. Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 30 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR George A. Weber | ADDRESS 705 S. Ann St

VS 150

117a

77752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77 6 77752

Registered No.

BTH NO. BC.49-17903

NAME OF DECEASED (Type or Print) Baby Boy Markell

2. DATE OF DEATH 8/26/49

PLACE OF DEATH: Baltimore City, Maryland Balto. Md.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 30 Md.
D. STREET ADDRESS (If rural, give location) 331 E. Hamburg St. 7-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	8/23/49			3		

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired) —

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Ellis Markell

14. MOTHER'S MAIDEN NAME Dorothy Vetters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. it means the disease, injury or complication which caused death.)

(A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO Premature Baby

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/23/49, 19__ *to* 8/26/49, 19__, *that I last saw the deceased alive on* 8/26, 1949 *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE J. L. Holbert M. D. | 23B. ADDRESS 1212 Light Street | 23C. DATE SIGNED 8/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY John Hopkins Medical School AUG 29 1949 | 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR AUG 30 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Commissioner of Health | ADDRESS

VS 150

159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

776 Registered No. 077753

077753

1. NAME OF DECEASED (Type or Print) Baby Boy Smith

2. DATE OF DEATH Aug 26, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto General Hosp

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 11
D. STREET ADDRESS (If rural, give location) 3906 Greenspring Ave

5. SEX male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH Aug 25, 1949 | 9. AGE (If under 1 year Months Days; If under 24 hours Hours Min.) 19

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Sidney Smith

14. MOTHER'S MAIDEN NAME Roslyn Fanny Albrecht

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mother ADDRESS 3906 Greenspring Ave

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prima Hepatitis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-25, 1949 *to* 8-26, 1949 *that I last saw the deceased alive on* 8-26, 1949 *and that death occurred at* 7:10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE James L. Gray M. D. | 23B. ADDRESS West Baltimore Gen. Hosp. | 23C. DATE SIGNED 8-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL | 24D. LOCATION (City, town, or county) (State) AUG 30 1949

DATE RECEIVED BY LOCAL REGISTRAR AUG 30 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Commissioner of Health | ADDRESS

VS 150

159

7754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE NO. B.C.49-18055 CERTIFICATE OF DEATH 776 Registered No. 07775:4

1. NAME OF DECEASED (Type or Print): CAROL ANN COOK

2. DATE OF DEATH: AUG. 28, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSP.

Length of stay in Baltimore: Yrs. 1 Mos. ____ Days ____

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: BORN IN HOSP. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location): 4016 Falls Rd. 13-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
IRL	W.	SINGLE	8/27/49			14 / 40

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired): INFANT
10B. KIND OF BUSINESS OR INDUSTRY: INFANT.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: WILLIAM ALBERT COOK
14. MOTHER'S MAIDEN NAME: GENEVIEVE MARY CHENOWETH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): IN PAINT
16. SOCIAL SECURITY NO.
17. INFORMANT: MOTHER ADDRESS: 4016 FALLS ROAD.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PREMATURITY
DUE TO
(B) PREMATURE LABOR
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/27, 1949, to 8/28, 1949, that I last saw the deceased alive on 8/28, 1949, and that death occurred at 3 30 A m., from the causes and on the date stated above.

23A. SIGNATURE: B. Amsterdam M. D.
23B. ADDRESS: Franklin Square Hosp.
23C. DATE SIGNED: 8/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State):
AUG 30 1949

DATE RECEIVED BY LOCAL REGISTRAR: AUG 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

159

James F Wolfe ✓

77755 — BALTIMORE CITY HEALTH DEPARTMENT — 60 — 77755

CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): James F. Wolfe

2. DATE OF DEATH: Aug. 28 49

PLACE OF DEATH: Baltimore City, Maryland 711 N. Madeira

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: 57 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 711 N. Madeira St 7-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	3-28-1892	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bar tender	Tavern	Maryland	U.S.A

13. FATHER'S NAME: Johann F. Wolfe

14. MOTHER'S MAIDEN NAME: Josephine Sedlacek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Answer yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	213-20-4211	Bohumil Wolfe	711 N. Madeira

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary artery disease	8 mos.
DUE TO (B)	arteriosclerosis	?
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	Diabetes Mellitus	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 8, 1949, *to* Aug. 28, 1949, *that I last saw the deceased alive on* Aug 28, 1949, *and that death occurred at* 1:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James F. Kleiner, M. D.	2623 E. Monument	Aug 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 31/49	Holy Redeemer	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 30 1949	Evelyn Williams, M.D.	Frank Grach & Son	Edmondson Ave

VS 150

61

0777756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0777756 Registered No.

TH NO BC.49-17149

1. NAME OF DECEASED (Type or Print): Baby Girl Jennings

2. DATE OF DEATH: 8/30/49.

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home + Hospital.

Length of stay in Baltimore: Yrs. 21. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 100 N. Broadway 6-05

5. SEX: F.
6. COLOR OR RACE: White.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single.
8. DATE OF BIRTH: 8/10/49
9. AGE (In years last birthday): ~~20 days~~ If Under 1 Year: Months / Days: 21 / If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired): INFANT
10B. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Baltimore.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ray Jennings. Jr.
14. MOTHER'S MAIDEN NAME: Joyce Hall.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): NO
(If yes, give war or dates of service): ~~None~~.
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS Joyce Jennings ADDRESS:

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hydrocephalus, spina Bifida — INTERVAL BETWEEN ONSET AND DEATH: 20 days
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/10/49, 19__, *to* 8/30/49, 19__, *that I last saw the deceased alive on* 8/30/49, 19__, *and that death occurred at* 2:40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lee M. Howard M. D.
23B. ADDRESS: Church Home and Hospital
23C. DATE SIGNED: 8/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 8-30-49
24C. NAME OF CEMETERY OR CREMATORY: Sentry Cemetery
24D. LOCATION (City, town, or county) (State): Boonesville, Virginia

DATE RECEIVED BY LOCAL REGISTRAR: AUG 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook Inc. ADDRESS: 1217 St. Paul St.

VS 150

157a

7:57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0777:57

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Norris, Walter

2. DATE OF DEATH Aug. 30, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-03
D. STREET ADDRESS (If rural, give location) 2036 Grend Mount Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	MARRIED	March 17, 1891	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer	Railroad	Balto. Md.	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr. Bronchiectasis — 5 yrs.
DUE TO Chr. Bronchitis & Asthma — 10 yrs.
(B) Arteriosclerotic Heart Disease.
DUE TO Generalized Arteriosclerosis ?
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 1, 1938 *to* Aug. 30, 1949 *that I last saw the deceased alive on* Aug. 30 1949 *and that death occurred at* 12:10 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert H. Ivy M. D.	Cal. & 30th St.	8-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	9/2/49	Leasys M. E.	Baltimore County Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 31 1949	Huntington Williams, M.D.	Wilhoms & Son	1217 Park Ave

VS 150

93D

- CERTIFICATE CORRECTED 9/7/49 ✓ 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0777:58 — 0777:58

RTH NO. — Registered No.

NAME OF DECEASED (Type or Print): THOMAS LAW

2. DATE OF DEATH: 8.30.49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 902 Stoll St 25-04

SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug 24. 1901 | 9. AGE (In years last birthday): 48 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter | 10B. KIND OF BUSINESS OR INDUSTRY: Building Const.

11. BIRTHPLACE (State or foreign country): Va | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Allman Law

14. MOTHER'S MAIDEN NAME: Ella Overstreet

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 227-07-9108

17. INFORMANT: Mrs Marion E Law | ADDRESS: 902 Stoll St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Shock - post operative bleeding into chest — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) pneumonectomy - pleurectomy

DUE TO Resection of Clavicle

(C) Carcinoma left lung

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 8.30.49 | 19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Lung | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m. | 21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8.29, 1949 to 8.30, 1949 that I last saw the deceased alive on 8.30 1949 and that death occurred at 1 30 P. m., from the causes and on the date stated above.

23A. SIGNATURE: Hamer M. Bissell M. D. | 23B. ADDRESS: University Hosp | 23C. DATE SIGNED: 8.30.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 9/1/49 | 24C. NAME OF CEMETERY OR CREMATORY: Rock Mount | 24D. LOCATION (City, town, or county) (State): Rocky Mount Va

DATE RECEIVED BY LOCAL REGISTRAR: AUG 31 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: W. W. Cole Sons | ADDRESS: 1219 E Paul St

VS 150

471

-131351

0777.3

BALTIMORE CITY HEALTH DEPARTMENT

TH NO. B.C.48-28699 CERTIFICATE OF DEATH Registered No. 0777.3

NAME OF DECEASED (Type or Print): Ray or Roy Timmerman

2. DATE OF DEATH: August 29-1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 637 W. Fayette Street 4-07

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Single	Dec. 24- 1948		8 / 5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Timmerman
14. MOTHER'S MAIDEN NAME: Helen Webster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes or unknown, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records- ADDRESS: Baltimore City Hospitals 4940 Eastern Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Diarrhea due to Malnutrition
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [ ] No [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-25- , 1949, *to* 8-29- , 1949 *that I last saw the deceased alive on* 8-29 - 1949, *and that death occurred at* 3.45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 8-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/1/49
24C. NAME OF CEMETERY OR CREMATORY: St Mary's
24D. LOCATION (City, town, or county) (State): Hamilton Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilmore & Son ADDRESS: 1214 E. Pratt St

VS 150

119a

7760 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 47760

CERTIFICATE OF DEATH

BIRTH NO.

NAME OF DECEASED (Type or Print): JAMES C. STONE

2. DATE OF DEATH: August 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

Length of stay in Baltimore: 10 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1619 Linden Ave. 14-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	White	Single	-------	66	--	--	--	--

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~None~~ WATCHMAN
10B. KIND OF BUSINESS OR INDUSTRY: BLDG-CONST.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? ----------
13. FATHER'S NAME: Francis Winfield Stone
14. MOTHER'S MAIDEN NAME: Mary E. Hunt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): -----
(If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: --------
17. INFORMANT: Mrs. Martha E. Roby ADDRESS: 514 Cathedral

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute peritonitis due to

DUE TO (B) Acute gangrene of intestine due to

DUE TO (C) Mesenteric Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: August 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/1/49	Cathedral Cemetery	Baltimore, Md.

DATE RECEIVED BY REGISTRAR: AUG 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. H. Meare and Son — ADDRESS: 805 N. Calvert St.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4500 Registered No. 077761

TH NO.

NAME OF DECEASED (pe or Print): GEORGE V. GREEN

2. DATE OF DEATH: Aug. 28, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF SPITAL OR STITUTION (If not in hospital or institution, give street address or location): 3219 Carlisle Ave.

Length of stay in Baltimore: Life -- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3219 Carlisle Ave.

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5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Dec. 6, 1857	91 yrs.		

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pilot	Pilot Ass. of Md.	Baltimore, Md.	

13. FATHER'S NAME: -

14. MOTHER'S MAIDEN NAME: -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Mrs. Sarah E. Green	3219 Carlisle Ave.

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A). Senility	Undet.
ANTECEDENT CAUSES	DUE TO (B) Generalized Arteriosclerosis	Undet.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 22 Aug., 1949, *to* 28 Aug., 1949, *that I last saw the deceased alive on* 24 Aug., 1949, *and that death occurred at* 3:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J Bradley Daugharthey M. D.	3033 W. North Ave	8-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/31/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 31 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. 077762

TH NO.

NAME OF DECEASED (pe or Print) SUSANNA C. WILSON	2. DATE OF DEATH Aug. 29, 1949
PLACE OF DEATH: Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Md.
FULL NAME OF SPITAL OR STITUTION (If not in hospital or institution, give street address or location) 3804 Woodridge Rd.	c. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
Length of stay in Baltimore Yrs. Mos. Days	b. STREET ADDRESS (If rural, give location) 3804 Woodridge Rd. 16-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	widow	Sept. 25, 1876	72 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	own home	Galena, Kent Co., Md.	

FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Taylor	Emma Chapman

WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		no	Mr. Francis E. Wilson	3804 Woodridge Rd.

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour

DUE TO

(B) Hypertension & Arteriosclerosis.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* February 1948 *to* Aug 29, 1949 *that I last saw the deceased alive on* Aug 29, 1949, *and that death occurred at* 1:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
DeWalter Spurrier M.D. M. D.	3603 Edmondson Ave	Aug 30 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/ /49	Lorraine Cem.	Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 31 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

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7763 — BALTIMORE CITY HEALTH DEPARTMENT — 330 — 077763

CERTIFICATE OF DEATH

7763 — TH NO. — Registered No. 077763

NAME OF DECEASED (Type or Print): Lancaster, Leonard

2. DATE OF DEATH: 8/30/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 720 main St. Reisterstown
D. STREET ADDRESS (If rural, give location): 720 Main St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W. Dowed
8. DATE OF BIRTH: Aug. 3, 1873
9. AGE (In years last birthday): 76 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Keeper
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis Lancaster
14. MOTHER'S MAIDEN NAME: Mary Ellen Wootten

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no.. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Thelma Bloom — ADDRESS: 720 Main St. Reisterstown

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1946 →
DUE TO
(B) Hypertension — Aug. 1949
DUE TO
(C) heart blocks.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____ 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Fred Hawkins Jr. M. D. — 23B. ADDRESS: Franklin Square Hosp. — 23C. DATE SIGNED: 8/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: Sept 1, 1949 — 24C. NAME OF CEMETERY OR CREMATORY: Mount Olivet — 24D. LOCATION (City, town or county) (State): Roslyn md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 31 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Wm. Berryman & Sons — ADDRESS: Reisterstown

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7764 — BALTIMORE CITY HEALTH DEPARTMENT — 077764

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

NAME OF DECEASED (Type or Print): ALBERT C. WISE

2. DATE OF DEATH: August 28, 1949

PLACE OF DEATH: Baltimore City, Maryland — Balto. City

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

Length of stay in Baltimore: All Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1600 Lafayette Avenue 16-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Single	Sept. 9. 1925	23		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elbert Wise

14. MOTHER'S MAIDEN NAME: Louise Surgeon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Louise Wise — ADDRESS: 1600 W. Lafayett Ave

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial degeneration

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X] *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: H. L. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: August 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Aug. 31. 1949

24C. NAME OF CEMETERY OR CREMATORY: John Weasley Cem.

24D. LOCATION (City, town, or county) (State): Anopolis Neck Md.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 31 1949

REGISTRAR'S SIGNATURE: Lillington for Williams, M.D.

25. FUNERAL DIRECTOR: Elroy O. Wilson — ADDRESS: 1000 Brantly Ave

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 3 077765

Registered No.

BIRTH NO. B.C.H-19308

NAME OF DECEASED (Type or Print) JAMES P. SULLIVAN

2. DATE OF DEATH August 30, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore, (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 908 Lemmon St. 16 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Single	2/10/45	4				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Samuel W. Sullivan

14. MOTHER'S MAIDEN NAME Viola A. Parker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Samuel W Sullivan ADDRESS 908 St. Lemmon

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Edema

DUE TO

(B) Epilepsy

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Earl Royer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED August 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9/1/49

24C. NAME OF CEMETERY OR CREMATORY New Cathedral

24D. LOCATION (City, town, or county) (State) 4200 Old Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR AUG 31 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John J. Cowan & Son

ADDRESS 85 Hoffman St.

S 151

766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

31

Registered No. 077766

TH NO.

NAME OF DECEASED (Type or Print) Robert Hastings

2. DATE OF DEATH Aug 28, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) 20 07
D. STREET ADDRESS (If rural, give location) 2213 W. Lexington St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White	Married	Feb 1, 1888	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Bldg. Const.	Scotland	U.S.A.

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Margaret V. Hastings ADDRESS 2213 W. Lexington St

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebrovascular Accident
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/27, 1949 *to* 8/28, 1949, *that I last saw the deceased alive on* 8/28, 1949, *and that death occurred at* 8:55 p m., *from the causes and on the date stated above.*

23A. SIGNATURE Jerome Gober M. D. | 23B. ADDRESS Sinai Hosp. | 23C. DATE SIGNED 8/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE Sept 1, 1949 | 24C. NAME OF CEMETERY OR CREMATORY Oaklawn Cem. | 24D. LOCATION (City, town, or county) Eastern Ave (State)

DATE RECEIVED BY LOCAL REGISTRAR AUG 31 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR John Tillery Jr. | ADDRESS 715 E. Fight St C. B. Hess Mgr.

VS 150

83a

77.7 BALTIMORE CITY HEALTH DEPARTMENT E 12.4 (7777.7

CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Boyd E. Rife N-803.

2. DATE OF DEATH 8/29/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY August
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1519 W. Baltimore St. 19-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Male	White	Divorced	12/4/1890	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer
10B. KIND OF BUSINESS OR INDUSTRY Sheet Metal
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME David J. Rife
14. MOTHER'S MAIDEN NAME Susan E. Part

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 226-10-6453
17. INFORMANT Carlie R. Rife ADDRESS 1519 W. Balto. St.

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of skull with purulent Meningitis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore & Gilmor St. 19/3
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 25, 1949 5:15 P.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Dr. George G. Merrill, per M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED August 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept. 49
24C. NAME OF CEMETERY OR CREMATORY MABEL MEMORIAL CEM
24D. LOCATION (City, town, or county) (State) HARRISONBURG Va

DATE RECEIVED BY LOCAL REGISTRAR AUG 31 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Rolff & B. M. Wacker ADDRESS Port Clarke

VS 151

170C

7708 CERTIFICATE CORRECTED 8-31-49 X ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

061 Registered No. 77708

TH NO.

NAME OF DECEASED (Type or Print): Willy F. Wendt

2. DATE OF DEATH: August 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: A.A.
C. CITY OR TOWN: Showacre
D. STREET ADDRESS (If rural, give location): Arnold, Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	12/27/1881	67 68		

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF: WHAT COUNTRY?
Engineer	Meat Packing Co.	Germany	

13. FATHER'S NAME: August Wendt

14. MOTHER'S MAIDEN NAME: Amelia ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	213-20-1278	Theresa M. Wendt	Arnold, Md.

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Tetanus	
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Plant	off of Wilkens Ave. Brunswick and Dulaney St Armor Packing Co. Plant Curtis Bay

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
August 21, 1949 ? m.	WHILE AT WORK [X] NOT WHILE AT WORK [ ]	Ran splinter in finger

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
Dr. George E. Merrill, per M.D.	[ ] / [X] / [ ]	August 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 1-49	Cedar Hill Cem	a a Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR
AUG 31 1949	Huntington Williams, M.D.	Robt C. & B. M. Walter

VS 151

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7769 | BALTIMORE CITY HEALTH DEPARTMENT | 51 | 077769

CERTIFICATE OF DEATH

STH NO. | Registered No.

NAME OF DECEASED (Type or Print): LUMAN L. METCALF

2. DATE OF DEATH: 8/30/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pine Ridge Nursing Home 4703 Hampnett Ave

Length of stay in Baltimore: 31 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-03
D. STREET ADDRESS (If rural, give location): 1515 W. Lombard St

3. SEX	5. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	5/4/1865	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery Business
10B. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Mass
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Coleman Metcalf
14. MOTHER'S MAIDEN NAME: Malinda Pope

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): No
16. SOCIAL SECURITY NO. (If yes, give war or dates of service): 212-12-2812A
17. INFORMANT: Jennie L. Metcalf 1515 W. Lombard St

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, stomach — Interval between onset and death: 6 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-25, 1949 *to* 8-30, 1949, *that I last saw the deceased alive on* 9-29, 1945, *and that death occurred at* 5.15 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John F. Schaefer M. D.	5103 Harford Road	8-30-49

24A. BURIAL, CREMATION OR REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 2-1949	New Cathedral	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 31 1949	Huntington Williams, M.D.	Roth & B. M. Walter	Stockton

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7770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

587.1

Registered No. 7770

TH NO.

NAME OF DECEASED (pe or Print): GEORGE W. WOLFF

2. DATE OF DEATH: 30 AUG. '99

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF SPITAL OR STITUTION (If not in hospital or institution, give street address or location): Bonsons Hospt

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 920 ashburton St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-06
D. STREET ADDRESS (If rural, give location) 920 Ashburton St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W	Single	May 13 1898	51		

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Paper Hanger	SELF	Balto Md.	

13. FATHER'S NAME: George Wolff.

14. MOTHER'S MAIDEN NAME: Martha E Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Martha E. Wolff. ADDRESS: 920 Ashburton St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS.

DUE TO

(B) CHRONIC PANCREATITIS — 3 MONTHS

DUE TO

(C) GASTRIC ULCER — 1 MONTH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/29, 1949 *to* 8/30, 1949 *that I last saw the deceased alive on* 8/30, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph R. Dolle M. D.	Bon Secours Hosp.	30 Aug. '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 2-49	Loudon Park	Frederick Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 31 1949	Huntington Williams, M.D.	Prob. by B. Ex. Walters	Pratt & Strickers

VS 150

117a

7771 — BALTIMORE CITY HEALTH DEPARTMENT — 450.0 — 977771

CERTIFICATE OF DEATH

BTH NO. 7771 — Registered No. 977771

NAME OF DECEASED (Type or Print): Charles E. Stump.

2. DATE OF DEATH: Aug 30 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR STITUTION (If not in hospital or institution, give street address or location): University Hospital.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland, B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore. Essex
D. STREET ADDRESS (If rural, give location): 10 Margaret Ave. ESSEX

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	SEPARTED	MAY 1 1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MECHANIC	MARTINS AIRPORT	Maryland.	

13. FATHER'S NAME: John C. Stump.

14. MOTHER'S MAIDEN NAME: Susan Mars (?) OR SUSANNA MYER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
NO		213-03-0164	MAMIE HOFSTETTER 15 SHARKLAND AVE

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 7

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None.		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 20 1949 *to* Aug 30, 1949, *that I last saw the deceased alive on* Aug 30, 1949, *and that death occurred at* 7:55 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H Patterson Meade M.D.	University Hospital	Aug 30 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	SEPT 1-49	SHARTZ	ODONNELL ST MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 31 1949	[illegible] Baltimore, Md	DIPPEL	3805 BOOELOMBARD ST

VS 150

97

777772 — BALTIMORE CITY HEALTH DEPARTMENT — 777772

CERTIFICATE OF DEATH

Registered No.

STH NO.

1. NAME OF DECEASED (Type or Print): Geo. Albert Johnson

2. DATE OF DEATH: 8-29-44

3. PLACE OF DEATH: Baltimore City, Maryland — 713 Bath

FULL NAME OF HOSPITAL OR INSTITUTION — (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 713 Bath — 15-01

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. Last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Colored	Married	8-23-1886	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10B. KIND OF BUSINESS OR INDUSTRY: APARTMENT HOUSE
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm Charles Johnson
14. MOTHER'S MAIDEN NAME: Harriet Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mary Lambson Johnson — ADDRESS: 713 Bath St

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-26-44 *to* 8-29-44 *that I last saw the deceased alive on* 8-29-44 *and that death occurred at* 6:25 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D. — 23B. ADDRESS: 2124 W. N. — 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 1st	Mt Auburn	Westport Md

DATE RECEIVED BY LOCAL REGISTRAR: 8-31-1944 — REGISTRAR'S SIGNATURE: [signature] Washington Williams, M.D. — 25. FUNERAL DIRECTOR: Joseph L. Russ — ADDRESS: 1200 McCulloh

VS 150

94a

977773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420. 1

Registered No. 977773

TH NO.

NAME OF DECEASED (Type or Print) PELAGIA URBANIAK

2. DATE OF DEATH AUG. 29, 1949

PLACE OF DEATH: Baltimore City, Maryland BALTO.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3400 DILLON STREET

Length of stay in Baltimore 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTO.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO.
D. STREET ADDRESS (If rural, give location) 3400 DILLON ST. 26-09

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	MARRIED	MAR. 17, 1876	73		

5. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	(PENSIONED)	POLAND	U.S.A

13. FATHER'S NAME
S JACOB PRUS

14. MOTHER'S MAIDEN NAME
UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT 3400 DILLON ST. ADDRESS
STANISLAUS URBANIAK

CAUSE OF DEATH

18.

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Atherosclerosis — Undetermined

DUE TO

(C) Chronic bronchitis — "

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August 25, 1949 *to* August 29, 1949, *that I last saw the deceased alive on* August 28 1949, *and that death occurred at* 10:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
I. B. Bronushas, M. D.	3037 O'Donnell St.	8-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	9/1/49	SACRED HEART OF MARY	GERMAN HILL ROAD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 31 1949	Hunter for Williams, M.D.	MARIE E. FIALKOWSKI	1000 S. HENWOOD AVE. 94a

VS-150

7774 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

077774 Registered No.

1. NAME OF DECEASED (Type or Print): Joseph W. Coleman

2. DATE OF DEATH: August 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 520 W. Biddle St. 17-01

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Married	5/12/1881	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Contractor	Rockbridge Co. Va.	U.S.A.

13. FATHER'S NAME: Joseph W. Coleman

14. MOTHER'S MAIDEN NAME: Emily Coleman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Marie Morgan ADDRESS: 1572 Jefferson Ave Buffalo, N.Y.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio-
DUE TO Vascular Disease
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH; BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. + Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: W. J. McClafferty M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED: August 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/2/49	Mt Auburn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 31 1949	Huntington Williams, M.D.	Chas. L. Law	802 Madison Ave

VS 151

93D

✓ Medical Examiner's Case

775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E90 2.0

Registered No. 777775

TH NO.

NAME OF DECEASED (Type or Print) RUTH KATZ — N-860.2

2. DATE OF DEATH AUG. 30, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE, INC

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-01

Length of stay in Baltimore 3 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2409 Brookfield Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	CHILD		15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) England

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Martin Katz

14. MOTHER'S MAIDEN NAME Merdane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Martin Katz ADDRESS 2409 Brookfield Ave

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemo-pneumothorax — INTERVAL BETWEEN ONSET AND DEATH: 6 HRS 17 min

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Intrapulmonary hemorrhage Traumatic

DUE TO

(C) poss. rupture of r lung

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

abrasions of [illegible]

CERTIFICATION APPROVED BY (Signature Block) For John R. Davis G.S. Merrill M.D.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (Give exact location)
Accident	Home	2409 Brookfield Ave.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
AUG. 30, 1949 3 p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Fell to ground. FROM A FALL (Fell from third story window)

22. I hereby certify that I attended the deceased from Aug. 30, 1949, to Aug. 30, 1949, that I last saw the deceased alive on Aug. 30, 1949, and that death occurred at 9:17 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
/s/ Robert L. Kaiser, M. D.	Sinai Hospital	8/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-31-49	Rosedale	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 31 1949	Huntington Williams, M.D.	Jack Lewis Inc	2100 Eutaw Pl

VS 150

186a

776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Vol. 1

Registered No. 077776

TH NO.

NAME OF DECEASED (Type or Print) Benjamin Albert

2. DATE OF DEATH Aug. 30, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 848 S. Sharp St.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital

Length of stay in Baltimore 40 Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	Aug. 5, 1885	64		20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer
10b. KIND OF BUSINESS OR INDUSTRY Grocery
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Abram Albert
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO None
17. INFORMANT Elizabeth Palbin ADDRESS Church Home & Hosp.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

DUE TO

(B) Infarction Of Myocardium - Coronary Thrombosis — 1 mos.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July. 29, 1949 to Aug. 30, 1949, that I last saw the deceased alive on Aug. 30, 1949, and that death occurred at 3:50 P. m. from the causes and on the date stated above.

23A. SIGNATURE James J. Means M.D. | 23B. ADDRESS Church Home & Hospital | 23C. DATE SIGNED Aug 30 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Interment | 24B. DATE 8-31-49 | 24C. NAME OF CEMETERY OR CREMATORY Hebrew Mt Carmel | 24D. LOCATION (City, town, or county) (State) Dalto Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 31 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Jack Lewis Inc | ADDRESS 2100 Eutaw Pl

VS 150

927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

751.1 Registered No. 077777

TH NO.

NAME OF DECEASED (Type or Print): Eva Schwartz

2. DATE OF DEATH: 8-31-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3466 Park Heights Ave

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	M		49		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Joseph Sandel
14. MOTHER'S MAIDEN NAME: Annie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Max Schwartz ADDRESS: 3466 Pk Hgts

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Polycystic kidneys - Congenital
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/12, 1949 *to* 8-31, 1949, *that I last saw the deceased alive on* 8/31, 1949, *and that death occurred at* 4:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jerome Gaber M. D. | 23B. ADDRESS: Sinai Hosp. | 23C. DATE SIGNED: 8/31/49

24A. BURIAL, CREMATION OR REMOVAL (Specify): Burial | 24B. DATE: 8-31-49 | 24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel | 24D. LOCATION (City, town, or county) (State): Dale, Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 31 1949 VS 150 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Jack Lewis Inc | ADDRESS: 2100 Eutaw Pl

133B

7778 — BALTIMORE CITY HEALTH DEPARTMENT — 077778

TH NO. — CERTIFICATE OF DEATH — Registered No.

A

NAME OF DECEASED (Type or Print): Margaret Schaffheis

2. DATE OF DEATH: Aug. 31, 1949

PLACE OF DEATH: Baltimore City, Maryland — Baltimore Md.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 77-48
D. STREET ADDRESS (If rural, give location): 513 Hollen Road.

Length of stay in Baltimore: Lifetime — Yrs. / Mos. / Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	March 12, 1909	40		

A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife.		Baltimore, Md.	U.S.

13. FATHER'S NAME: William F. Downey, Sr.

14. MOTHER'S MAIDEN NAME: Margaret Groves

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): no or unknown

16. SOCIAL SECURITY NO.: 219-20-8231

17. INFORMANT: Husband — ADDRESS: 511 Hollen Rd.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of lungs. — INTERVAL BETWEEN ONSET AND DEATH: 4 Mos.

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Carcinoma of Ovaries.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 29, 1949, *to* Aug 31, 1949 *that I last saw the deceased alive on* Aug 31, 1949, *and that death occurred at* 5:05 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Mary E. Matthews M. D.	Mercy Hospital	Aug 31 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Sept. 3-1949	Moreland Memorial Park	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 31 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Rd

VS 150

49a

779 X ✓ E 977.° 077779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): NORA E. STRASSBERGER N-874-2

2. DATE OF DEATH: August 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR STITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Harundale GLEN-BURNIE
D. STREET ADDRESS (If rural, give location): 1420 Instead Street 1420 ISTEAD RD.

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	MARRIED	MARCH 3, 1921	28		

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired): HOUSEWORK
10B. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S
13. FATHER'S NAME: EDWARD FLYNN
14. MOTHER'S MAIDEN NAME: ANNIE T. KEARNS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: HUSBAND ADDRESS: 1420 ISTEAD Rd.
ARUNAH A. STRASSBERGER

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hemorrhage
DUE TO
(B) Stab wound of neck
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY, (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1420 Instead Street, Harundale, A.A.Co.
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: August 29, 1949 ?A.m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Sharp Instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy / Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl L Rogers M.D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Aug 29 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: SEPT. 1 1949
24C. NAME OF CEMETERY OR CREMATORY: HOLY CROSS CEMETERY
24D. LOCATION (City, town, or county) (State): ANNE ARUNDEL COUNTY

DATE RECEIVED BY LOCAL REGISTRAR: AUG 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. Walter Conklin
ADDRESS: 2343 Hanford Rd.

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(641) ✓

7780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077780

TH NO.

NAME OF DECEASED (Type or Print) Harry Jennings

2. DATE OF DEATH 8 30 49

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY Balto.

ULL NAME OF SPITAL OR TITUTION (If not in hospital or institution, give street address or location) 805 N. Wilmot St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 16-07

Length of stay in Baltimore 46 yrs. Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 805 N. Wilmot St.

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Negro	Divorced	8-2-1	48		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur TRUCK DRIVER	WHOLESALE PAINTS	Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Jennings	Frances Sarah Spriggs

WAS DECEASED EVER IN U.S. ARMED FORCES? (no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No		Marie Craig	805 N. Wilmot

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Occlusion	8 hours.
	DUE TO	
ANTECEDENT CAUSES		
	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 29, 1949, *to* Aug 30, 1949, *that I last saw the deceased alive on* Aug 29, 1949, *and that death occurred at* 8 A.M. *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	612 Edmondson Ave.	8-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/2/49	Cathedral	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 31 1949	Huntington Williams, M.D.	Geo. C. Nelson	1303 Presstman St.

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077781

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E983 077781 Registered No.

RTH NO.

NAME OF DECEASED (Type or Print): Paulena Evans N-991

2. DATE OF DEATH: Aug 28. 49

PLACE OF DEATH: Baltimore City, Maryland South Corn

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md
D. STREET ADDRESS - (If rural, give location): 9 Quay Alley 22-01

Length of stay in Baltimore: 5 years (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Col	-		27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-	Nil	Va	

13. FATHER'S NAME: James Evans

14. MOTHER'S MAIDEN NAME: Mary L Thomson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Alice Evans ADDRESS: 1020 S Fremont Ave

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Strangulation

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 9 Quay Alley

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): August 28, '49 ? a. m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Strangulation (manual)

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Earl L Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 29 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: Aug 31. 49

24C. NAME OF CEMETERY OR CREMATORY: La. Cross Ba

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: AG 31 1949

REGISTRAR'S SIGNATURE: Tunstall Williams, M.D.

25. FUNERAL DIRECTOR: Isaac L Brown Son ADDRESS: 108 W Montgomery St

168

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(FOR APPROVAL BY MED. EXAMINER)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X

Registered No. 077782

RTH NO. 077782

NAME OF DECEASED (Type or Print) ROGER E WALL 473

2. DATE OF DEATH August 30, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

Length of stay in Baltimore Nine ~~Years~~ Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN Baltimore 7
D. STREET ADDRESS (If rural, give location) 1708 Daniels Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	April 1, 1924	25	4	29		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist

10B. KIND OF BUSINESS OR INDUSTRY Doughnut Machine

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Roy Wall

14. MOTHER'S MAIDEN NAME Ella Linder ✓

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) World War 2

16. SOCIAL SECURITY NO. 220-18-4544

17. INFORMANT Mrs. Elizabeth Wall ADDRESS 1708 Daniels Ave, Baltimore 7, Md.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE LARYNGEAL EDEMA — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (B) ACUTE PULMONARY EDEMA

DUE TO (C) ACUTE PASSIVE CONGESTION LIVER & KIDNEYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST. (TOXIEMIA) ACUTE ULCERATIVE TONSILLITIS

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If not at home, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY occur?

CERTIFICATION APPROVED BY
for C. Gardner Pugh, M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John H. Lewis M. D.	St. Agnes Hosp.	8/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/3/49.	St. John's Cemetery	Ellicott City, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 31 1949	Huntington Williams, M.D.	Easton Sons	Ellicott City, Md.

115B

077783

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 077783

174 Registered No.

TH NO.

NAME OF DECEASED (Type or Print): KATHRYN E. White

2. DATE OF DEATH: Aug. 30 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1727 Montpelier ST. 9-07

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 2-18-84
9. AGE (In years last birthday): 65
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Johnston
14. MOTHER'S MAIDEN NAME: Patricia Lindsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of uterus
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Coronary arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/31, 1949 *to* 8/30, 1949, *that I last saw the deceased alive on* 8/30, 1949, *and that death occurred at* 7:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: John H. Angell M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-2-49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Pk
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: AUG 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck
ADDRESS: 5305 Harford Rd.

4813

Dr. Haase 077784

TH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170

077784 Registered No.

NAME OF DECEASED (Type or Print): Louise F. Tatem

2. DATE OF DEATH: Aug. 30, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3019 Ailsa Avenue

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3019 Ailsa Avenue 27-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	Dec. [illegible], 1899	49				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Maryland	

13. FATHER'S NAME: John Muhlenfeld

14. MOTHER'S MAIDEN NAME: Mary Schlutter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. Wm. A. Tatem	3019 Ailsa Avenue

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma left breast

DUE TO

(B) Lymphoid hyperplasia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
May 30, 1949	Co above	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Good, 1949 *to* May, 1949, *that I last saw the deceased alive on* Aug. 29, 1949, *and that death occurred at* 1:50 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[illegible] M. D.	4218 Harford Rd.	8-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-2-49	Loudon Park	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
AUG 31 1949	Huntington Williams, MD	Leonard J. Rack, 5305 Harford Road.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 0777785

TH NO. 0777785 Registered No.

NAME OF DECEASED (Type or Print): EMILIE WILLEM

2. DATE OF DEATH: AUG. 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3505 Rosekemp Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3505 Rosekemp Avenue

Length of stay in Baltimore: Yrs. Mos. Days

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	married	Sept. 19, 1870	78		

10. USUAL OCCUPATION (Give kind of business during most of working life, even if retired): at home
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Thom
14. MOTHER'S MAIDEN NAME: Marie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. John Willem, 3505 Rosekemp Ave. ADDRESS

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malnutrition

DUE TO

(B) Generalized arteriosclerosis
c nephrosclerosis.

DUE TO

(C) Pulmonary Edema, anasarca

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 25, 1949 *to* August 29, 1949, *that I last saw the deceased alive on* Aug 29, 1949 *and that death occurred at* 12:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph L. Matchar M. D.
23B. ADDRESS: 3623 Liberty Heights
23C. DATE SIGNED: August 30 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-1-49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: 1949
REGISTRAR'S SIGNATURE: Kimberly for Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Buck, 5305 Harford Road ADDRESS

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33 ✓ 077786 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Anna Eckelman

2. DATE OF DEATH Aug. 31, 1949

PLACE OF DEATH: Baltimore City, Maryland 1400 N. Lexington St.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) aged Women's and aged Men's Homes

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 19-07
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	May 9, 1862	87	3 / 22	

10. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Herman S. Eckelman

14. MOTHER'S MAIDEN NAME Adelaide

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT L. H. Read ADDRESS 1400 N. Lexington St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

(B) Cerebral Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 21, 1949, to August 31, 1949, that I last saw the deceased alive on August 30, 1949, and that death occurred at 5:00 a.m., from the causes and on the date stated above.

23A. SIGNATURE Howland Edward Day M. D. | 23B. ADDRESS 4-E-33rd St-18 | 23C. DATE SIGNED Aug 31/1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 24B. DATE 9/2/49 | 24C. NAME OF CEMETERY OR CREMATORY Baltimore | 24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 31 1949 | REGISTRAR'S SIGNATURE Huntington Williams, MD | 25. FUNERAL DIRECTOR Wilson & Dye | ADDRESS 1217 Eutaw St

VS 150

838

077787 × Moring ✓ 077787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) John Moring

2. DATE OF DEATH August 30, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore 6 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Towson
D. STREET ADDRESS (If rural, give location) 600 Annesley Rd.

3. SEX	5. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	7/27/99	50		

6. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10a. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Refrigeration	Prince Edward Co Va	

13. FATHER'S NAME John Moring

14. MOTHER'S MAIDEN NAME Mattie Nichols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) World War I

16. SOCIAL SECURITY NO. 579-03-3825

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-30, 1949 *to* 8-30, 1949, *that I last saw the deceased alive on* 8-30, 1949, *and that death occurred at* 5:40 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Phelps J. Nagley M. D.	JOHNS HOPKINS HOSPITAL	8-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		National Cem	Arlington Va

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
AUG 31 1949	Huntington Williams, M.D.	Henry W. Plumpe & Son Co	4903 York Rd

83a

077788 1 ✓ 077788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

610 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Ivins, Mr Harry O

2. DATE OF DEATH 30 Aug 49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital

Length of stay in Baltimore 10 Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md
B. COUNTY Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen
D. STREET ADDRESS (If rural, give location) 12 Mt Royal

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	W	married	24 May 1886	63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist

10B. KIND OF BUSINESS OR INDUSTRY Drug Store

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ivins, George

14. MOTHER'S MAIDEN NAME Carr, Katherine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT Ivins, Mr Harry O ADDRESS Aberdeen Md

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Yellow Atrophy of Liver — INTERVAL BETWEEN ONSET AND DEATH: 4 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acute terminal Nephritis — 4 day

DUE TO

(C) —

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Retro Pubic Prostatectomy — 26 Aug

19A. DATE OF OPERATION 26 Aug 49

19B. MAJOR FINDINGS OF OPERATION Benign Prostatic Hypertrophy

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 20 Aug, 1949 *to* 30 Aug, 1949 *that I last saw the deceased alive on* 30 Aug, 1949 *and that death occurred at* 11 P *m.; from the causes and on the date stated above.*

23A. SIGNATURE Osborne L Ensberg M. D.

23B. ADDRESS Church Home & Hosp

23C. DATE SIGNED 31 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Sept 2nd 1949

24C. NAME OF CEMETERY OR CREMATORY Front

24D. LOCATION (City, town, or county) (State) Fillsboro Harford Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 31 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Henry Tarring Hess

ADDRESS 137a Aberdeen Md

077789

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

077789 Registered No.

TH NO. B.C. 49-03563

NAME OF DECEASED (Type or Print) Fannie May Thomas

2. DATE OF DEATH Aug. 30, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 146 N. Gaten St

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore — Yrs. Mos. Days

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	6. DATE OF BIRTH	6a. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored		2-19-49		6 mo 11 da	

7a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
7b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME Bonnie Thomas
14. MOTHER'S MAIDEN NAME Nellie Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS JOHNS HOPKINS HOSPITAL

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dehydration - Hyperelectrolytemia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
DUE TO
(B) Acute - Nutritional Disturbance — 6 days
DUE TO
(C) ? Dysentery — 4

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/29 1949 to 8/30 1949 that I last saw the deceased alive on 8/30 1949, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

23a. SIGNATURE John F. Crigler, Jr. M.D.
23b. ADDRESS JOHNS HOPKINS HOSPITAL
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE aug 31 49
24c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem
24d. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR AUG 31 1949
REGISTRAR'S SIGNATURE Edward Mitchell, M.D.
25. FUNERAL DIRECTOR Elroy O. Wilson
ADDRESS 1010 Bronty Rd

VS 150

119a

Sophie

077790 BALTIMORE CITY HEALTH DEPARTMENT 077790

CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Sophie (2) Rudl Burke

2. DATE OF DEATH August 30, 1949

PLACE OF DEATH Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2242 Mura St.

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-4
D. STREET ADDRESS (If rural, give location) 2242 Mura Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widowed	10-20-1885	63		

9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Baltimore-Md	

13. FATHER'S NAME John N. Fanton

14. MOTHER'S MAIDEN NAME Elizabeth Rudl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Frances Burke ADDRESS 2242 Mura Street

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		INTERVAL BETWEEN ONSET AND DEATH
(A)	Cerebral hemorrhage	8 hrs.
DUE TO (B)	Hypertensive CV dis	
DUE TO (C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* February, 1941, *to* August 30, 1949, *that I last saw the deceased alive on* Aug. 30, 1949, *and that death occurred at* 9 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ronald Landon M. D.	6077 Harford Rd.	8-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-2-49	Baltimore Cem.	North Ave. Balto. - Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
	Huntington Williams, M.D.	John C. Miller Inc.	2435 E. Chase St.

VS 150
AUG 31 1949

937

RTIFICATE 9/7/49

BALTIMORE CITY HEALTH DEPARTMENT

RTH NO 077791 CERTIFICATE OF DEATH Registered No. 077791

EN 802.7

NAME OF DECEASED (Type or Print) INGWALT JOHANSEN (INGVALD T. JOHANSON

2. DATE OF DEATH August 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospital

Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, 25-5
D. STREET ADDRESS (If rural, give location) 4805 Pennington Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Male	White		Aug. 13- 1882	43 (67)				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Captain
10B. KIND OF BUSINESS OR INDUSTRY Shipping
11. BIRTHPLACE (State or foreign country) Norway
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Abrahom Johnson
14. MOTHER'S MAIDEN NAME Not Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no or unknown
16. SOCIAL SECURITY NO. 215-03-7768
17. INFORMANT Mary Johnson 4805 Pennington Ave. ADDRESS

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fractured skull
DUE TO Intracranial hemorrhage
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Clinton St., in front of Pier #1 26/6
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 29, 1949 Approx. 7:50 a.m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Ped. struck by auto and then thrown under the wheels of a tractor-trailer

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED 8/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/1/49	Holy Cross	a.a.Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR C.D. Fanning & Son - 1938 E. Lafayette ADDRESS Ave.

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077792 ✓ X 077792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 155

STH NO. Registered No.

NAME OF DECEASED (Type or Print): RALPH BROOKS KLINE

2. DATE OF DEATH: 8-31-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

Length of stay in Baltimore: Yrs. 15 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Cecil
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NORTH EAST
D. STREET ADDRESS (If rural, give location): NORTHEAST, MD.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: MARCH 5, 1904
9. AGE (In years last birthday): 45
If Under 1 Year: Months - Days -
If Under 24 Hours: Hours - Min. -

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad (B&O)
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JACOB KLINE
14. MOTHER'S MAIDEN NAME: LAURA HOLDEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 705-10-0842
17. INFORMANT: Daughter MRS. [illegible] McCRAW ADDRESS: Same

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) GENERALIZED CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS
DUE TO
(B) PRIMARY LIVER CELL CARCINOMA — 6 months
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* August 16, 1949 *to* Aug. 31, 1949 *that I last saw the deceased alive on* Aug 31, 1949, *and that death occurred at* 11:20 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 8/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-3-49
24C. NAME OF CEMETERY OR CREMATORY: Methodist
24D. LOCATION (City, town, or county) (State): North East, Cecil Co Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 3 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Joseph R Grant
ADDRESS: North East Md

46F

077793 BALTIMORE CITY HEALTH DEPARTMENT 077793

CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Hicks, Ada

2. DATE OF DEATH: 8/31/49

PLACE OF DEATH: Baltimore City, Maryland Sinai Hospital

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

Length of stay in Baltimore: Unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Essex
D. STREET ADDRESS (If rural, give location): 835 Middle River Rd Essex #20

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Wid	July 14-1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VA
12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Sinai Hospital ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema

DUE TO

(B) Cardiac failure

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/23 19 49 *to* 8/31 19 49 *that I last saw the deceased alive on* ____ 19 ____, *and that death occurred at* 7:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Nathan Thal M. D.
23B. ADDRESS: Sinai Hospital Baltimore
23C. DATE SIGNED: 8/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 8/31/49
24C. NAME OF CEMETERY OR CREMATORY: Rural Retreat, Va
24D. LOCATION (City, town, or county) (State): Whyte Co., Va.

DATE RECEIVED BY LOCAL REGISTRAR: AUG 31 1949
REGISTRAR'S SIGNATURE: Deputy Registrar
25. FUNERAL DIRECTOR: Ray D. Wheeler
ADDRESS: 403-825 N. Ave

EARL B. WOLVERTON 111c

7794 JL- 129399

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G77794 Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Elizabeth S arah Graham

2. DATE OF DEATH: 8-31-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits write RURAL and give township): Baltimore 10-22
D. STREET ADDRESS (If rural, give location): 1111 Wilmot Ct-2

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	White	Married	Dec.19,1894	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Martin Kennedy
14. MOTHER'S MAIDEN NAME: Bridget Kennedy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: B. C. H. Records, ADDRESS: 4940 Eastern Ave.

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Multiple Myeloma

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ Yes ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-4-49, 19__, *to* Aug. 31, 1949 *that I last saw the deceased alive on* Aug. 31 1949 *and that death occurred at* 2 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 8-31-49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial
24B. DATE: 9/3/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 1 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook, Inc. ADDRESS: 1217 St. Paul st.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

F 902 D

Registered No. 777795

TH NO.

NAME OF DECEASED (Type or Print): JOHN BURLEY N-857.0

2. DATE OF DEATH: August 30, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-1
D. STREET ADDRESS (If rural, give location): 708 S. Hanover Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	8-12-1886	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: O-A-P

11. BIRTHPLACE (State or foreign country): Anne Arundel Co., Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ike Burley
14. MOTHER'S MAIDEN NAME: Heneritta Gover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown, so state) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Martha Brown ADDRESS: 2520 Mc Culloh St.

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subaracknoid Hemorrhage

DUE TO Multiple rib fractures.

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 708 S. Hanover Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): August 30, 1949 2:30 A.M.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Imagined house was afire and Jumped from third story window

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: W. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 8-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-2-1949	Mt Auburn	Baltimore City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 1 - 1949	Huntington Williams, M.D.	J. L. Brown & Son	108 W Montgomery St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (or Print) Mary I. Gross

2. DATE OF DEATH August 29, 49

PLACE OF DEATH: altimore City, Maryland Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1007 Leadenhall St.

Length of stay in Baltimore 40 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 23-1
D. STREET ADDRESS (If rural, give location) 1007 Leadenhall Street

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	W	May 12, 1887	62		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME layton Johnson

14. MOTHER'S MAIDEN NAME Alice ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Viola Johnson ADDRESS 1007 Leadenhal l

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 10 days

DUE TO

(B) Malnutrition

DUE TO

(C) & Cachexia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

over

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/ /49 *to* 8/29/49, *that I last saw the deceased alive on* 8/29/49, *and that death occurred at* 10:25 *m., from the causes and on the date stated above.*

23A. SIGNATURE Wm Conner M. D. | 23B. ADDRESS 253 Cary St | 23C. DATE SIGNED 8/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/1/1949 | 24C. NAME OF CEMETERY OR CREMATORY Mt Calvary | 24D. LOCATION (City, town, or county) (State) A. A. Co., Md

DATE RECEIVED BY DOCTOR REGISTRAR SEP 1 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR D L Brown & Son | ADDRESS 1082 W Montgomery St

VS 150

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AB-131193

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 344 777917

TH NO. B.C. 28-1944 Registered No.

NAME OF DECEASED (Type or Print): Harvey James Burrows

2. DATE OF DEATH: August 30-1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN: Baltimore
(If outside corporate limits, write RURAL and give township): 4-2
D. STREET ADDRESS (If rural, give location): 744 Fayette St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	Negro	Single	Sept-12-1948		11			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Burrows
14. MOTHER'S MAIDEN NAME: Evelyn Burrows

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals Records- ADDRESS 4940 Eastern Ave.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.)
(A) Hydrocephalus
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 8-24-49
19B. MAJOR FINDINGS OF OPERATION: Ventricular tap & injection of dye
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-19- , 19 49 *to* 8-30- , 19 49 *that I last saw the deceased alive on* 8-30- , 19 49 *, and that death occurred at* 3.15 A.M. *, from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 8-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/3/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): B.C. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 1 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Halstead
ADDRESS: 198 Dund Ave

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

41 Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Jesse E. Thompson

2. DATE OF DEATH: Aug 30, 1949

PLACE OF DEATH: Baltimore City, Maryland 16 W. Hill St

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-1
D. STREET ADDRESS (If rural, give location): 16 W. Hill St

Length of stay in Baltimore — Yrs. Mos. Days

SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 25 1900
9. AGE (In years last birthday): 49
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): W. Va
12. CITIZEN OF WHAT COUNTRY? USA.

FATHER'S NAME: Found Thompson
14. MOTHER'S MAIDEN NAME: Lena White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Naomi Thompson ADDRESS: 16 W. Hill

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 8 mos.
DUE TO
(B) Chronic Bronchial Asthma. — 2 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 5 1949 *to* Aug 30 1949 *that I last saw the deceased alive on* Aug 30 1949 *and that death occurred at* 11:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: 1239 Gilmor St
23C. DATE SIGNED: 8/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: Sept 2, 1949
24C. NAME OF CEMETERY OR CREMATORY: Stevensville Cem.
24D. LOCATION (City, town, or county) (State): Stevensville Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 1 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John Thlenny Inc
ADDRESS: 715 Light St
927

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

19 5 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) FRANCIS G. WOLCOTT

2. DATE OF DEATH AUG 31, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

Length of stay in Baltimore UNKNOWN Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE FLORIDA
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) CLEARWATER
D. STREET ADDRESS (If rural, give location) 918 FLORIDA ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	MAY 27, 1902	47		

A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INSURANCE AGENT	INSURANCE	OHIO	USA

13. FATHER'S NAME GUY F. WOLCOTT

14. MOTHER'S MAIDEN NAME NORA MAE GAISER

A. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
UNKNOWN		262-09-8690	Hospital Records	

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PITUITARY ADENOMA - POST OPERATIVE

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
AUG 29, 1949	PITUITARY ADENOMA	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 27 Aug, 19 49, *to* 31 Aug, 19 49, *that I last saw the deceased alive on* 31 Aug, 19 49, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Arlie Burdine M. D.	Union Memorial Hospital	31 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	9/1/49	Clearwater	Clearwater, Fla.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 1 - 1949	Huntington Williams, MD	WM. J. TICKNER & SONS	Balto., Md.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 1 077800 Registered No.

TH NO. B.

NAME OF DECEASED (Type or Print): Mrs. Louise Aldom

2. DATE OF DEATH: August 30, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

Length of stay in Baltimore: 4 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-10
D. STREET ADDRESS (If rural, give location): 4605 York Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Dec. 8, 1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hwfe.
10B. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Henry Baker
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Mr. Robert W. Aldom — ADDRESS: 4605 York Rd.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/17/ , 1949, to 8/30/ , 1949 *that I last saw the deceased alive on* 8/30/ , 1949 , *and that death occurred at* 1:30PM *from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Surisla M. D.
23B. ADDRESS: 1440 N. Caroline Street
23C. DATE SIGNED: 8/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/1/49
24C. NAME OF CEMETERY OR CREMATORY: Meadowridge Cem.
24D. LOCATION (City, town, or county) (State): Howard Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, Mgr.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150

61

77801 — BALTIMORE CITY HEALTH DEPARTMENT — 077801

TH NO.

CERTIFICATE OF DEATH

231 Registered No.

NAME OF DECEASED (Type or Print): MAGGIE JANE DAVIS

2. DATE OF DEATH: Aug. 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2437 Reisterstown Rd.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-4
d. STREET ADDRESS (If rural, give location): 2437 Reisterstown Rd.

3. SEX	5. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	widow	Nov. 15, 1883	65 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Evergreen, W. Va.	

13. FATHER'S NAME: Jessie Fitchgerald

14. MOTHER'S MAIDEN NAME: Mary Toms

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	Mrs. Lola M. Fury	2437 Reisterstown Rd.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 15, 1945 *to* Aug. 29, 1949 *that I last saw the deceased alive on* Aug 25, 1949 *and that death occurred at* 1 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
N. E. Needle M. D.	814 - 20 N. Howard St.	8/30/49.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/1/49	Loudon Park Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 1 - 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

8-3a

77802 — BALTIMORE CITY HEALTH DEPARTMENT — 200:1 — 077802

CERTIFICATE OF DEATH

TH NO. — Registered No.

NAME OF DECEASED (Type or Print): Carrie E. McGregor

2. DATE OF DEATH: August 30, 1949

PLACE OF DEATH: Baltimore City, Maryland 1114 E. 20th St.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-8
D. STREET ADDRESS (If rural, give location): 1114 E. 20th Street,

Length of stay in Baltimore — Yrs. Mos. Days

SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 29, 1874
9. AGE (In years last birthday): 74 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Schreiber
14. MOTHER'S MAIDEN NAME: Catherine Selman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Joseph H. McGregor — ADDRESS: 1114 E. 20th St

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Intestinal Obstruction	10 days
DUE TO		
(B)	Lymphosarcoma	8 months
DUE TO		
(C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1948 *to* Aug. 30, 1949 *that I last saw the deceased alive on* Aug 30, 1949, *and that death occurred at* 8.20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 7122 Harford Rd, Balto. 14.
23C. DATE SIGNED: Aug 31. 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 3, 1949
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 1 - 1949
REGISTRAR'S SIGNATURE: [signature] Registrar of Vitals, Md.
25. FUNERAL DIRECTOR: Ullrich Funeral Home — ADDRESS: 2008 Orleans St.,

VS 150

55E

7803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59-0 Registered No. 77803

TH NO.

NAME OF DECEASED (Type or Print) Mita RADOSAV

2. DATE OF DEATH Aug 31-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3104 Wilkins Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore B. COUNTY City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 3104 Wilkins Ave
D. STREET ADDRESS (If rural, give location) 20-6

Length of stay in Baltimore 40 yrs. (Yrs. Mos. Days)

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	W	Widowed	1877?	72?				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker
10B. KIND OF BUSINESS OR INDUSTRY Steel
11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME unknown
14. MOTHER'S MAIDEN NAME unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no or unknown
16. SOCIAL SECURITY NO. 213-19-3745
17. INFORMANT John E McCormack ADDRESS 3104 Wilkins Ave

CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis of Liver — 2 yrs
DUE TO
(B) None
DUE TO
(C) None

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 1, 1949 *to* Aug 31, 1949, *that I last saw the deceased alive on* 8/31, 1949 *and that death occurred at* 6:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Benjamin Miller M. D.
23B. ADDRESS 20 30 Wilkens Ave
23C. DATE SIGNED 8/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept 3-49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION (City, town, or county) (State) Frederick Ave ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR SEP 1 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR Robert C. & B. Jr. Walters

VS 150

124 B

077804

TH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51

077804

Registered No.

AME OF DECEASED (e or Print): Amelia L. Buppert

2. DATE OF DEATH: August 30, 1949

LACE OF DEATH: Baltimore City, Maryland

ULL NAME OF SPITAL OR TITUTION (If not in hospital or institution, give street address or location): 3106 Spaulding Ave.

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-17
D. STREET ADDRESS (If rural, give location): 3106 Spaulding Ave.

EX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
emale	White	Widowed	Oct. 4, 1869	79 yrs		

USUAL OCCUPATION (Give kind of one during most of working life, even if retired)	10a. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
None	—	Baltimore County, Md.	

FATHER'S NAME: John Subock

14. MOTHER'S MAIDEN NAME: Josephine Schaible

WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	—	—

17. INFORMANT: Mrs. Edna Piel — ADDRESS: Woodlawn, Md.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 18 mos
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* December 1, 1946 *to* August 30, 1949, *that I last saw the deceased alive on* August 19, 1949, *and that death occurred at* 6.30A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. Arthur Rossberg M.D. M. D.	2411 Washington Blvd.	8/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 2, 1949	Druid Ridge Cemetery	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 1 - 1949	Huntington Williams, M.D.	J. Kelly Lamborn	4510 Liberty Heights Ave.

VS 150

46B

977805

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

977805

TH NO. 977805 — Registered No. 6,10

NAME OF DECEASED (Type or Print): Edward Fishpaw

2. DATE OF DEATH: August 31, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital.

Length of stay in Baltimore: 20 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: Baltimore.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Timonium.
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married.	Feb. 29, 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Railroad.	Maryland	USA

13. FATHER'S NAME: Emanuel Fishpaw.

14. MOTHER'S MAIDEN NAME: Mariah Sheeler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		717-01-6933	Mrs. Louella Fishpaw	Timonium, Md.

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular disease. — 15 yr.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Benign Prostatic hypertrophy

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
August 24, 1949.	Benign Prostatic hypertrophy & urethreal obstruction	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Aug 11, 1949, to Aug 31, 1949, that I last saw the deceased alive on Aug 31, 1949, and that death occurred at 8:15 p m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Patterson Mack, M. D.	University Hospital, Balto.	9-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 3, 1949	Poplar Grove Cem.	Cockeysville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 1 1949	Huntington Williams, M.D.	JOHN BURNS' SONS,	Towson, Md.

VS 150

1272

077806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54

077806

Registered No.

TH NO.

NAME OF DECEASED (or Print) JOHN EMMETT FLEISHELL

2. DATE OF DEATH August 31 1949

PLACE OF DEATH: Baltimore City, Maryland 1660 Shadyside Dr

FULL NAME OF HOSPITAL OR INSTITUTION — (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 9-2
D. STREET ADDRESS (If rural, give location) 1660 Shadyside Dr

Length of stay in Baltimore — Yrs. Life Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	2-2-1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shelf Work
10B. KIND OF BUSINESS OR INDUSTRY: Bethel Steel Co
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Anthony Fleishell
14. MOTHER'S MAIDEN NAME: Susan Hutton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-09-7676
17. INFORMANT: John S. Fleishell — ADDRESS: 1660 Shadyside Dr

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO
(B) Carcinoma of rectum — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
February 21, 1949	Carcinoma rectum with liver metastases	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. I hereby certify that I attended the deceased from August 20, 1949, to August 31, 1949 that I last saw the deceased alive on Aug 30, 1949. and that death occurred at 10 a. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frederick J. Vollmer M. D.	6100 York Road	Aug. 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 3 1949	New Cathedral	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 1 - 1949	Huntington Williams, M.D.	John A. Moran	3000 E. Balto St.

VS 150

469

177807 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 177807

TH NO.

CERTIFICATE OF DEATH

NAME OF DECEASED (Type or Print): Joseph Pratt

2. DATE OF DEATH: Aug. 31, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 561 Hoffman St.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township) 17-2
D. STREET ADDRESS (If rural, give location): 561 Hoffman St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Col.	Married	April 25, 1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St. Mary's County, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Pratt
14. MOTHER'S MAIDEN NAME: Jane Mugg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary V. Pratt ADDRESS: 561 Hoffman St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Enterocolitis
DUE TO
(B) Heart Disease
DUE TO
(C) Malnutrition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/12/49 *to* 8/31/49 *that I last saw the deceased alive on* 8/31/49 *and that death occurred at* [illegible] *m. from the causes and on the date stated above.*

23A. SIGNATURE: Wm Cramer M. D.
23B. ADDRESS: 552 Cathedral St
23C. DATE SIGNED: 9/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 3, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Memorial
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: Sep 1 1949
REGISTRAR'S SIGNATURE: Hunter Worthington Williams, M.D.
25. FUNERAL DIRECTOR: Charles H. Alexander ADDRESS: 1205 McCulloh, Baltimore

937

. Szczepicki
1802 Eastern Ave.
TH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

60 677808
Registered No.

NAME OF DECEASED (Type or Print): Frederick H. Hinz

2. DATE OF DEATH: Aug. 31, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3125 Rosalie Avenue

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-5
D. STREET ADDRESS (If rural, give location): 3125 Rosalie Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	married	Nov. 16, 1890	58		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Black & Decker		Germany	

13. FATHER'S NAME: Daniel Hinz

14. MOTHER'S MAIDEN NAME: Mary Hulse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Anna C. Hinz, ADDRESS: 3125 Rosalie Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Instant

DUE TO

(B) Chronic Myocarditis — 8 yrs.

DUE TO

(C) Hypertension, Diabetes, Nephritis, Arteriosclerosis. — 10 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. , 1940 *to* Aug. 31 , 1949 *that I last saw the deceased alive on* Aug. 30, 1949 *and that death occurred at* 17:30 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE: John V. Szczepicki M. D.

23B. ADDRESS: 1802 Eastern Ave

23C. DATE SIGNED: 8-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 9-3-49

24C. NAME OF CEMETERY OR CREMATORY: Parkwood

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 1 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Leonard J. Ruck, ADDRESS: 5305 Harford Road.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

TH NO. Registered No.

NAME OF DECEASED (Type or Print): EDWARD OUTTOUN N-804.2

2. DATE OF DEATH: August 24, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR STITUTION (If not in hospital or institution, give street address or location): Mery Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Illinois
B. COUNTY:
C. CITY OR TOWN: Chicago
(If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 811 S. State Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		?	91		

9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10a. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
?	?	?	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: L. J. Ruck ADDRESS: 5305 Harford Rd

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull
DUE TO (B) Intracranial Hemorrhage
(B) Contusion of brain.
DUE TO (C) Fractured right femur.
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): City Hall

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): City Hall--Lexington & Holiday Sts.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): August 23, 1949 m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? FEll down dteps 4/1

22. *I certify that I took charge of the remains described above, held an* Partial autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 8-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 9-3-49

24C. NAME OF CEMETERY OR CREMATORY: Moreland Park

24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 1 - 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: Leonard J. Luck ADDRESS: 5305 Harford

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1949 Registered No. 77810

TH NO.

NAME OF DECEASED (Type or Print) ERNEST OSCAR RAFSTEDT

2. DATE OF DEATH Sept. 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Hyman Pk. Drive & 31st St.

Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pa. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Philadelphia
D. STREET ADDRESS (If rural, give location) 2713 Newkirk St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	9/26/99	49		

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
AB seaman	Seafarer	Mass.	USA

FATHER'S NAME: Oscar Rafstedt

14. MOTHER'S MAIDEN NAME: Maria Pederson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown	Unknown	Records-	US Marine Hospital, Balto, Md.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Astroblastoma left occipital lobe — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 17, 1949 *to* Sept. 1, 1949 *that I last saw the deceased alive on* Sept. 1 1949 *and that death occurred at* 2:55A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Wilson John L. Wilson, Medical Director M. D.	US Marine Hospital, Balto, Md.	9/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/1/49	Mt Carmel	Philadelphia Pa

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 1 1949	Evelyn Williams, M.D.	Wilson Coffee	1217 N Broad St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77 Registered No. 77811

TH NO.

NAME OF DECEASED (Type or Print) STEPHEN WARHOLY

2. DATE OF DEATH 31 AUG 49

PLACE OF DEATH: Baltimore City, Maryland 2711 W. Carey St

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-6
D. STREET ADDRESS (If rural, give location) 2703 N. Howard ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	About 1880	About 68	

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10B. KIND OF BUSINESS OR INDUSTRY Roland Turkish Bath

11. BIRTHPLACE (State or foreign country) Hungary
12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME (Unknown) Warholly

14. MOTHER'S MAIDEN NAME Unknown

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Elmer H. Vogler ADDRESS 775 W. Saratoga St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Prostate with metastases

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 21 July, 1949 *to* 31 Aug, 1949, *that I last saw the deceased alive on* 30 Aug, 1949, *and that death occurred at* 4:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Emil H. Henning Jr M. D. | 23B. ADDRESS 4580 Edmondson Ave | 23C. DATE SIGNED 31 Aug 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/2/49 | 24C. NAME OF CEMETERY OR CREMATORY London Park | 24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 1 - 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Wm Cook Inc. | ADDRESS 1217 St. Paul St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0778:2

TH NO.

Registered No.

NAME OF DECEASED (Type or Print) William Morgan

2. DATE OF DEATH Aug. 26, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1125 N. Mulberry St

Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1125 N. Mulberry St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-2
D. STREET ADDRESS (If rural, give location) 1125 N. Mulberry St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	C	married	Aug. 10, 1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer - Retired	?	Baltimore, md.	U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT Victoria Morgan ADDRESS 1125 N. Mulberry

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio Vascular Degeneration

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH ?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 26, 1949, to Aug 28, 1949, *that I last saw the deceased alive on* Aug. 26, 1949 *and that death occurred at* 10 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D. W. R. Johnson	703 Medford Bldg	8/31/49

24A. BURIAL, CREMATION OR REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	Sept 1, 1949	Mt. Auburn	Baltimore	Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 1 1949 REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Mc Katie R Williams ADDRESS 322 N. Schroeder St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

077813

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) John T. Johnson

2. DATE OF DEATH 8/31/49

PLACE OF DEATH: Baltimore City, Maryland Balto. Md.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 705 N. Gilmor St

Length of stay in Baltimore 35 Yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-2

D. STREET ADDRESS (If rural, give location) 705. N. Gilmor St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	Col.	Married	1892	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY Barber

11. BIRTHPLACE (State or foreign country) Va

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Johnson

14. MOTHER'S MAIDEN NAME Louise —

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or Unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Pearl Johnson ADDRESS 705. Gilmor St

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 24hrs

DUE TO

(B) Generalized Arterio Sclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-17, 1949 *to* 8-31, 1949 *that I last saw the deceased alive on* 8-31, 1949, *and that death occurred at* 11:00 P *m., from the causes and on the date stated above.*

23A. SIGNATURE H. Thrombosis Phillips M. D. | 23B. ADDRESS 1543 Penna Ave | 23C. DATE SIGNED 9/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/3/49 | 24C. NAME OF CEMETERY OR CREMATORY Mt Auburn | 24D. LOCATION (City, town, or county) (State) West Port.

DATE RECEIVED BY LOCAL REGISTRAR SEP 1 - 1949 | REGISTRAR'S SIGNATURE Cuthbert Williams, M.D. | 25. FUNERAL DIRECTOR Metropolitan Funeral Home Inc. | ADDRESS 927. N. Mount St

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77814

TH NO.

Registered No.

NAME OF DECEASED (Type or Print): Katherine Geary

2. DATE OF DEATH: Aug 30th 1949

PLACE OF DEATH: Baltimore City, Maryland 1131 Scott st

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1131 Scott St Baltimore
D. STREET ADDRESS (If rural, give location): 1131 Scott St. 21-1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Nov 12th 1873	75	9 / 18	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown, give war or dates of service): NO
16. SOCIAL SECURITY NO: —
17. INFORMANT: Catherine Geary — ADDRESS: 1131 Scott St.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Few days.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Coronary Arteria - Sclerosis — Years.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 2, 1945 *to* Aug. 30, 1949, *that I last saw the deceased alive on* Aug. 30, 1949, *and that death occurred at* 6.30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Frank M. Ogden M. D.
23B. ADDRESS: 2701 N. Calvert St.
23C. DATE SIGNED: Sept. 1, 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 3rd 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross Cem.
24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 1 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: B. L. Harle — ADDRESS: 1000 S. Paca St

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77815 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 077815

CERTIFICATE OF DEATH

E 983.0

TH NO.

NAME OF DECEASED (Type or Print): Edison (ADD 1500) Burrell — N-803.7 — 2. DATE OF DEATH: August 31, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 16-2
D. STREET ADDRESS (If rural, give location): 1117 Woodyear St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C		Sept. 10, 1885	63		

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired): None (Blind)
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Gloucester Co. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Addison Burrell, Sr.
14. MOTHER'S MAIDEN NAME: Martha Fox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Rev. A.J. Spence — ADDRESS: 918 S. 24th. St. Phila. Pa.

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pituitary tumor Syphilitic aortitis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1117 Woodyear St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): August 22, 1949 ?m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Blunt force

22. *I certify that I took charge of the remains described above, held an* [redacted] Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 1, 1949

24A. BURIAL CREMATION REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-2-1949	Zion Hill	Gloucester Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 1 - 1949
REGISTRAR'S SIGNATURE: Luther Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home — ADDRESS: 1631 Druid Hill Ave

VS 151

168

7816 — BALTIMORE CITY HEALTH DEPARTMENT — 57 — 077816

CERTIFICATE OF DEATH

TH NO. B.C.48-19111 — Registered No.

NAME OF DECEASED (Type or Print): Richard Johnson

2. DATE OF DEATH: August 31, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1325 Mosher St.

Length of stay in Baltimore: Yrs. 11 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-2
D. STREET ADDRESS (If rural, give location): 1325 Mosher St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	C	Single	Sept. 5, 1948		11	26

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Morris Johnson
14. MOTHER'S MAIDEN NAME: Mary Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If known) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mary Johnson — ADDRESS: 1325 Mosher St

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gastro-enteritis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: H. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: August 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-2-1949	Mt. Auburn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 1 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home — ADDRESS: 1611 Druid Hill Ave 119a

VS 151

078.17

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 8 9 4 078.17 Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Clyde Keaton N-803.7

2. DATE OF DEATH: August 25, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New York
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): N. Y. City
D. STREET ADDRESS (If rural, give location): 44 Whitehall St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	June 12, 1918	31		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: NOAH KEATON
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Crushed Skull
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Erdman Ave. 800 ft. W. of North Point Rd
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: August 25, 1949 9:50 PM
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Auto into auto into wooden pole 26/4

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☒ / ASSISTANT MEDICAL EXAMINER ☐ / MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: August 26, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 3 1949
24C. NAME OF CEMETERY OR CREMATORY: Claiborne Cemetery
24D. LOCATION (City, town, or county) (State): Tenn.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 1 - 1949
REGISTRAR'S SIGNATURE: Geo. [illegible]
25. FUNERAL DIRECTOR: Mrs. J. D. Elliott
ADDRESS: Sept 1949 N. Carol St

VS 151

170C

7818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Vol. 1 077818

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Medley Band.

2. DATE OF DEATH August 31, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore 23 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Owings Mills.
D. STREET ADDRESS (If rural, give location) Rosewood Training School.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	White	married	5-8-90	59		1

A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Attendant	Hospital	Kentucky	U.S.A.

13. FATHER'S NAME Isbel Band.

14. MOTHER'S MAIDEN NAME Margaret Boggess

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown		JOHNS HOPKINS HOSPITAL	

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction - acute

DUE TO

(B) coronary artery atherosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-31 1949 to 8-31, 1949, *that I last saw the deceased alive on* 8-31, 1949, *and that death occurred at* 5:45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter Arons M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 4-1949	Lawrenceburg	Lawrenceburg - Ky.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 2 - 1949	Huntington Williams, M.D.	Frank H. Mecorll.	Pikesville, Md.

VS 150

94a

819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077819

TH NO.

NAME OF DECEASED (Type or Print) Silvine Von D Slingluff Marbury

2. DATE OF DEATH Aug 31 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 159 W. Lanvale St

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-2
D. STREET ADDRESS (If rural, give location) 159 W. Lanvale St

Length of stay in Baltimore 60 yrs (Yrs. Mos. Days)

3. SEX F.
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH Oct 2 1867
9. AGE (In years last birthday) 81
If under 1 year: Months Days
If under 24 hours: Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Co Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles Bohn Slingluff
14. MOTHER'S MAIDEN NAME Valerie von Dorsner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Wm R. Marbury Jr. Glenrock Rd.

CAUSE OF DEATH

18.

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary infarction, — 7-10 days
DUE TO left lower lobe
(B) Arteriosclerotic cardio- — years
DUE TO vascular disease
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 18, 1949 to Aug 31, 1949 that I last saw the deceased alive on Aug 31, 1949, and that death occurred at 9:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE James R. Harris M. D.
23B. ADDRESS 700 Cathedral St
23C. DATE SIGNED Sept 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct 2 1949
24C. NAME OF CEMETERY OR CREMATORY London Park
24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 2 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Henry W. Jenkins Sons Co
ADDRESS 4905 York Rd

VS, 150

937

820

TH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 977820

Registered No.

NAME OF DECEASED (Type or Print): WILLIAM C. HAMBLETON

2. DATE OF DEATH: Sept. 1st, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3419 Woodstock Ave

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived? If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 3419 Woodstock Ave. 8-1

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: June 9th, 1867
9. AGE (In years last birthday): 82 — If under 1 year: Months 2, Days 22 — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman
10B. KIND OF BUSINESS OR INDUSTRY: Continental Can Co.
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: B. Hambleton
14. MOTHER'S MAIDEN NAME: Emma Ewing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 218-09-6980

17. INFORMANT: Miss Eatha Hambleton — ADDRESS: 3419 Woodstock Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days.
DUE TO
(B) Cardio-Vascular Hypertensive Disease. — 10 years.
DUE TO
(C) Arteriosclerosis — 10 years.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 15, 1948, *to* Sept 1, 1949, *that I last saw the deceased alive on* Sept 1, 1949, *and that death occurred at* 12:25A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Michael J. Dousch M. D.
23B. ADDRESS: 4636 Belair Road
23C. DATE SIGNED: 9-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 9/3/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 2 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Rossehn Funeral Home — ADDRESS: 7401 Belair Rd.

VS 150

937

821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

151 077821

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Caroline G. Lapp

2. DATE OF DEATH 8/31/49 2:30 P.M.

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 436 Random Road

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 25-31
D. STREET ADDRESS (If rural, give location) 436 Random Road

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years; last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	7/7/1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Andrew Snyder
14. MOTHER'S MAIDEN NAME Augusta Greise
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT John C. Snyder ADDRESS 436 Random Rd

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH 3 months
DUE TO
(B)
DUE TO
(C) Exhaustion
Cerebral Determination ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION June 1949
19B. MAJOR FINDINGS OF OPERATION Carcinoma of Stomach
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-23 ~~1949~~ *to* 8-31, 1949 *that I last saw the deceased alive on* 8-30, 1949, *and that death occurred at* 2:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE John P. Welch Jr. M. D.
23B. ADDRESS 1227 Wash Blvd
23C. DATE SIGNED 9-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9/3/49
24C. NAME OF CEMETERY OR CREMATORY Western
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY REGISTRAR SEP 2 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1217 St. Paul St.

VS 150

46B

7822 — 443 — 077822

TH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

AME OF DECEASED (e or Print): CORA MAY LUDWIG

2. DATE OF DEATH: 1:00 a.m. 8-31-1949

LACE OF DEATH: Baltimore City, Maryland

ULL NAME OF SPITAL OR TITUTION (If not in hospital or institution, give street address or location): 113 Gwynns Falls Pkwy

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 15-47
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
STREET ADDRESS (If rural, give location): 3113 Gwynns Falls Parkway

EX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	White	married	Nov-24-1878	70		

10. USUAL OCCUPATION (Give kind of one during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	—	Baltimore Md.	

FATHER'S NAME: Thomas Leonard Ways

14. MOTHER'S MAIDEN NAME: Clara Hanson

WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		—

17. INFORMANT: Mildred Bauer — ADDRESS: 3113 Gwynns Falls Pk

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) organic heart disease — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

(B) hypertension — unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 14- , 1941, *to* 8-31 - , 1949, *that I last saw the deceased alive on* 8-30 - , 1949 *and that death occurred at* 1:00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chester Riland M.D. M. D.	2532 Edmondson ave	8-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 3-49	Druid Ridge	Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SP 2-1949	Huntington Williams, M.D.	G. Howard Strong	3207 W North ave

VS 150.

95c

8823 — BALTIMORE CITY HEALTH DEPARTMENT — 4 yr. 1 0778823

TH NO. — **CERTIFICATE OF DEATH** — Registered No.

NAME OF DECEASED (Type or Print): MRS ANNA ADES

2. DATE OF DEATH: SEPT. 2, '49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

Length of stay in Baltimore: 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-13
D. STREET ADDRESS (If rural, give location): 2629 Quantico Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	White	married		54		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ades wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Frank
14. MOTHER'S MAIDEN NAME: Yetta
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Rubew Ades — ADDRESS: 2629 Quantico Ave

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	PERIPHERAL CIRCULATORY COLLAPSE	1/2 hr
DUE TO (B)	MYOCARDIAL INFARCTION	10 hrs
DUE TO (C)	HYPERTENSIVE CARDIOVASCULAR DISEASE	5 yrs

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1, 19 49, *to* Sept 2, 19 49, *that I last saw the deceased alive on* Sept 2, 19 49, *and that death occurred at* 1 25 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leon E. Kassel, M. D. — 23B. ADDRESS: Sinai Hospital — 23C. DATE SIGNED: 9/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-2-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herzog Mem
24D. LOCATION (City, town, or county) (State): Balto Md
DATE RECEIVED BY LOCAL REGISTRAR: SEP 2 - 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc — ADDRESS: 2100 Eutaw Pl

VS 150

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7824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0777824

TH NO. Registered No.

NAME OF DECEASED (Type or Print) Goldberg ; Rebecca

2. DATE OF DEATH 1 Sept 49

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY 27-18

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

Length of stay in Baltimore Life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 4803 Reisterstown Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	4/18/99	49 50 yrs		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Operator	Raincoat	Balto Md	

13. FATHER'S NAME Abraham

14. MOTHER'S MAIDEN NAME Lena Yanick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Lena Handler ADDRESS 4803 Reist Rd

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of oesophagus - DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 8/15/49 Esophagoscopy 8/17/49 Gastrostomy (Biopsy)

19B. MAJOR FINDINGS OF OPERATION Squamous cell Ca of Oesophagus

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/12 *, 1949, to* 1 Sept. *, 1949, that I last saw the deceased alive on* 1 Sept. *, 1949, and that death occurred at* 4.00 A. *m., from the causes and on the date stated above.*

23A. SIGNATURE Eugene P. Aberlin M. D.

23B. ADDRESS Sinai Hospital

23C. DATE SIGNED 1 Sept 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9-2-49

24C. NAME OF CEMETERY OR CREMATORY Hebrew Herring Run

24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 2 - 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Lewis Inc

ADDRESS 2100 Eutaw Pl

VS 150

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8,25

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

175 Registered No. 0778,25

TH NO.

NAME OF DECEASED (Type or Print)
Minnie Wagner,

2. DATE OF DEATH Sept. 1, 1949

PLACE OF DEATH:
Baltimore City, Maryland 1730 N. Wolfe St.,

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY

C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) 8-6

D. STREET ADDRESS (If rural, give location) 1730 N. Wolfe St.,

Length of stay in Baltimore — Yrs. Mos. Days

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	White	Widowed	August 17, 1884	65		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
t home		Baltimore, Md.	

13. FATHER'S NAME
Louis Koehler

14. MOTHER'S MAIDEN NAME
Sophia Kram

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
O.		Charles A. Wagner	1730 N. Wolfe St.,

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Topic Absorption — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

(B) Carcinoma of Ovaries — 1 year.

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 25 1949	Carcinoma of Ovaries	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 5, 1949, *to* Sept 1, 1949, *that I last saw the deceased alive on* Sept 1, 1949, *and that death occurred at* 7:15A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Michael F. Dausch M. D.	4636 Belair Road,	9-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept, 5, 1949	Holy Redeemer	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 2 1949	Huntington Williams, M.D.	Ullrich Funeral	Home 2008 Orleans St.,

VS 150

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78826
TH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 78826

NAME OF DECEASED (Type or Print): Anna Pitts

2. DATE OF DEATH: Aug. 30/49

PLACE OF DEATH: Baltimore City, Maryland — 1197 N. Rose St.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 6-2
D. STREET ADDRESS (If rural, give location): 1197 N. Rose St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If under 1 Year: Months, Days	If under 24 Hours: Hours, Min.
Female	W.	Married	Sept 24/89	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: — Hoffman
14. MOTHER'S MAIDEN NAME: Catherine ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Arthur Pitts — ADDRESS: 1197 N. Rose St. (24)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO

(B) ARTERIOsclerodic Cardio Vasc Disease — 5 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 29, 1949, to Aug 30, 1949, *that I last saw the deceased alive on* Aug 30 1949, *and that death occurred at* 11:35 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Benjamin Berdinsky, M. D. | 23B. ADDRESS: 2507 Hooker St | 23C. DATE SIGNED: Aug 31 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Sept. 3/49 | 24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn | 24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: SEP 2 - 1949 | REGISTRAR'S SIGNATURE: Emmerton for Williams, M.D. | 25. FUNERAL DIRECTOR: Philip Herwig Sons | ADDRESS: 2024 Orleans St

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3-27

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

201

1778-27

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) EARL C. BARBER	2. DATE OF DEATH Aug. 30, 1949
PLACE OF DEATH: Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1920 W. Lanvale St.	C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) 16-4
Length of stay in Baltimore 12 yrs. (Yrs. Mos. Days)	D. STREET ADDRESS (If rural, give location) 1920 W. Lanvale St.
5. SEX ale / 6. COLOR OR RACE white / 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Aug. 10, 1885 / 9. AGE (In years last birthday) 64 yrs. / If Under 1 Year: Months Days / If Under 24 Hours: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter / 10b. KIND OF BUSINESS OR INDUSTRY own business	11. BIRTHPLACE (State or foreign country) Limerock, N. Y. / 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Barber	14. MOTHER'S MAIDEN NAME Elizabeth Clark
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown) no / (If yes, give war or dates of service) / 16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Eva M. Barber ADDRESS 1920 W. Lanvale St.

18. CAUSE OF DEATH

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A)	Hodgkins Disease	3 yrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)		
	DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 19 49, *to* Aug 30, 19 49, *that I last saw the deceased alive* Aug 30, 19 49, *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE S. Mendelis M. D.	23B. ADDRESS 651 N Bentalou	23C. DATE SIGNED 9/1/49
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/2/49	24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cem. / 24D. LOCATION (City, town, or county) (State) Howard Co., Md.
DATE RECEIVED BY LOCAL REGISTRAR SEP 2 - 1949	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR WM. J. TICKNER & SONS / ADDRESS Balto., Md.

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7828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. 077828

TH NO.

NAME OF DECEASED (Type or Print): Mary Anna Baker

2. DATE OF DEATH: 8-30-1949

PLACE OF DEATH: Baltimore City, Maryland — 1211 Broward St

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1211 Broward St

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 1211 Broward St. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 11-2
D. STREET ADDRESS (If rural, give location): 1211 Broward St

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	C	Widow	2-12-1889	60		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Raleigh, N.C.	U.S.A.

13. FATHER'S NAME: Charles Montague

14. MOTHER'S MAIDEN NAME: Maria Jones.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			Annie Hammond	

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Apoplexy — Interval between onset and death: 4 days.
DUE TO
(B) Hypertension — Interval between onset and death: Unknown.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Dehydration, Chr. Glom. Nephritis — Interval between onset and death: Unknown.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-25, 1949 *to* 8-30, 1949 *that I last saw the deceased alive on* 8-30, 1949, *and that death occurred at* 1 [illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
N. Leland Powell Jr. M. D.	902 W. Franklin	9-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-2-49	New Cathedral	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 2 - 1949	Deputy for Williams, MD	Wm Kaiser Williams & Sons	822

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✓ x 177 0778/29

9829

TH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

NAME OF DECEASED (Type or Print): Mary Tracy

2. DATE OF DEATH: 9-1-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2263 Madison Ave

Length of stay in Baltimore: 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: D.C.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington
D. STREET ADDRESS (If rural, give location): 1412 Third Street N.W.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F.	Colored	Married	3-14-09	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Chapman Fitzhugh
14. MOTHER'S MAIDEN NAME: Mary Burroughs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown). (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hattie Fitzhugh ADDRESS: Baltimore, Md

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.
DUE TO
(B) fundus of uterus (ca)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-9, 1949 to 9-1, 1949 that I last saw the deceased alive on 9-1, 1949 and that death occurred at 9:10 P m., from the causes and on the date stated above.

23A. SIGNATURE: G. Franklin Phillips M. D.
23B. ADDRESS: 1543 Penna. Ave
23C. DATE SIGNED: 9/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-5-49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Wash., D.C.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 2 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles L. Law ADDRESS: 802 Madison Ave - 1

VS 150

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860

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

TH NO.

Registered No. 077860

NAME OF DECEASED (Type or Print) (KIRK BANDELL) CURT P. BANDEL

2. DATE OF DEATH August 31, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR STITUTION (If not in hospital or institution, give street address or location) South Balto. Gen. Hosp.

Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE California
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sante Cruz
D. STREET ADDRESS (If rural, give location) 317 Ocean

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	Approx. 1898	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chief Mate	P.T.S.S. Navigator	Germany	U.S.A.

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ?

17. INFORMANT Pope and Talbott Inc. ADDRESS 401 Garrett Bldg.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute congestive cardiac failure

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Coronary arteriosclerosis
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED 8-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	9-2-49	Greenmount Cem.	Balto. Md.

DATE RECEIVED BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 1 - 1949	Huntington Williams, M.D.	Wm Cook Inc	1217 St Paul St Balto Md.

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TH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 977831

NAME OF DECEASED (Type or Print): THEODORE BUSCHMAN

2. DATE OF DEATH: 8-30-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

Length of stay in Baltimore: 55 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-4
D. STREET ADDRESS (If rural, give location): 51-S- Fulton Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	Oct. 6- 1881	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Peddler	B & O - R.R.	Germany	USA.

13. FATHER'S NAME: Julius Buschman

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Fred W. Buschman	- Same

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PULMONARY EDEMA

DUE TO

(B) BRONCHOPNEUMONIA

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CARCINOMA of STOMACH

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-28 1949 *to* 8-30 1949 *that I last saw the deceased alive on* 8-30 1949, *and that death occurred at* 5:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Arnold H. Michael M. D.	Sinai Hospital of Balto.	8-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 2 '49	Westview Cem.	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 2 - 1949	Huntington Williams, M.D.	H. B. Wagaman & Son	1100 Eutaw

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Send to Medical Examiner's Office for approval.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E954.7

Registered No. 077832

STH NO.

NAME OF DECEASED (Type or Print) ROBERT LEE NICHOLSON N-9774 | 2. DATE OF DEATH 9-1-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL

Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)
A. STATE MD. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-8
D. STREET ADDRESS (If rural, give location) 4146 Falls Road

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	SINGLE	Oct. 6. 1932	16		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At School	—	Maryland	U.S.A.

13. FATHER'S NAME: Paul E. Nicholson

14. MOTHER'S MAIDEN NAME: Lillian V. Easton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or Unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	Paul E. Nicholson	4146 Falls Road

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Post operative dead due to Anesthesia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

CERTIFICATION APPROVED BY
G. H. Merrill
For: C. J. Lubinski, M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9-1-49	PLASTIC REPAIR OF NOSE	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Hospital	University Hospital

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
September 1, 1949 9 a.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Pentothal anesthesia

22. *I hereby certify that I attended the deceased from* 9-1, 1949 *to* 9-1, 1949, *that I last saw the deceased alive on* 9-1, 1949, *and that death occurred at* 10:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Herbert K. Jones M.D.	University Hosp.	9-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	Sept. 5-1949	Lorraine Park	Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 2-1949	Thurlington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49 3 0778833

TH NO. Registered No.

NAME OF DECEASED (Type or Print) WOODSON TURNEY

2. DATE OF DEATH Sept. 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

Length of stay in Baltimore 19 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) 27-14
D. STREET ADDRESS (If rural, give location) 5505 Rusk Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Mar.	9/28/73	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tenn.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Turney
14. MOTHER'S MAIDEN NAME: Unknown Hannah Graham

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or Unknown) Yes Unknown (If yes, give war or dates of service) 1st World
16. SOCIAL SECURITY NO. 215-07-8249
17. INFORMANT: Records- ADDRESS: US Marine Hospital, Balto, Md.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Unresolved organizing pneumonia with chronic adhesive pleuritis — INTERVAL BETWEEN ONSET AND DEATH: Unknown
(B) DUE TO:
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 29, 1949, *to* Sept. 1, 1949, *that I last saw the deceased alive on* Sept. 1, 1949, *and that death occurred at* 12:25 AM *from the causes and on the date stated above.*

23A. SIGNATURE John L. Wilson
John L. Wilson, Medical Director M.D.
23B. ADDRESS: US Marine Hospital, Balto Md.
23C. DATE SIGNED: 9/1/49

24A. BURIAL, CREMATION OR REMOVAL (Specify): Burial
24B. DATE: Sept. 3-1949
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: Sep 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home
ADDRESS: 3623 Falls Rd.

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TH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

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Reg'o. 1 0778.34

Registered No.

NAME OF DECEASED (Type or Print) Mary M. Eyerly

2. DATE OF DEATH 9/4/49

PLACE OF DEATH: Baltimore City, Maryland 1501 Fortaw

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore Life 73 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1501 Fortaw Balto Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md.
D. STREET ADDRESS (If rural, give location) 1501 Fort ave. 23-2

3. SEX	5. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W.	Married	9/4/1875	73				

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto Md

12. CITIZEN OF WHAT COUNTRY? USA

15. FATHER'S NAME Thomas Conway

14. MOTHER'S MAIDEN NAME Martha Russell

16. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Chas J. Eyerly ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — 10 yrs

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 6, 1949 *to* Sept 1, 1949 *that I last saw the deceased alive on* Sept 1, 1949, *and that death occurred at* 3:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. N. Wheeler M. D.	1279 Gilham Pl	Sept 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/3/49	Cedar Hill	Ritchie Highway

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 2 - 1949	Huntington Williams, M.D.	J. J. Bailey Sons	1318 Light

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077835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

077835 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) RICHARD WITHERSPOON

2. DATE OF DEATH 9-1-49.

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2532 FRANCIS STREET

Length of stay in Baltimore 7 YEARS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) BALTIMORE 17. 13-3
D. STREET ADDRESS (If rural, give location) 2532 FRANCIS STREET

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	COLORED	MARRIED	2-8-1913	36	5 / 30	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	BETH. STEEL CO.	LAKE CITY S.C.	U.S.A.

13. FATHER'S NAME MARTIN WITHERSPOON

14. MOTHER'S MAIDEN NAME EVELYN McFADDEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
		ITLEAN WITHERSPOON	2532 FRANCIS ST.

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pulmonary Tuberculosis	
ANTECEDENT CAUSES	DUE TO (B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

CERTIFICATION APPROVED
For Dr. W.G. Helfrich
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/31/49 to 8/31, 1949, that I last saw the deceased alive on 8/31, 1949 and that death occurred at 2 P.M. from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Evan D. Bilke M. D.	601 N. Calhoun St	9/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	9-5-49.	MT. AUBURN	BALTIMORE, MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 2 - 1949 VS 150	Huntington Williams, M.D.	Wm. A. JACKSON	916 PENNA. AVE.

130

077836

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

077836

TH NO. _____ Registered No. _____

NAME OF DECEASED (Type or Print): LUCY DAVIS

2. DATE OF DEATH: August 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-2
D. STREET ADDRESS (If rural, give location): 1069 W. Fayette Street

Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

3. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 3-17-1901
9. AGE (In years last birthday): 48 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): BALTIMORE MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: HEZ LAWSON
14. MOTHER'S MAIDEN NAME: LIZZIE RICH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: GEO. DAVIS ADDRESS: 1069 W. FAYETTE ST.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocardial degeneration

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 8-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 9-2-49
24C. NAME OF CEMETERY OR CREMATORY: MT. AUBURN
24D. LOCATION (City, town, or county) (State): BALTIMORE MD.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 2 - 1949
REGISTRAR'S SIGNATURE: Winterton Williams, M.D.
25. FUNERAL DIRECTOR: Wm. A. JACKSON ADDRESS: 916 PENNA. AVE

93D

0778837

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

5 0778837

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) White, Baby Boy

2. DATE OF DEATH Sept 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN Baltimore
If outside corporate limits, write RURAL and give township) 25-06
D. STREET ADDRESS (If rural, give location) 1447 Binder Court, Fairfield

Length of stay in Baltimore 1 DAY ~~Yrs.~~ ~~Mos.~~ ~~Days~~

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
M	N	Single	August 31, 1949				9	30

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10a. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INFANT	none	Maryland	

FATHER'S NAME Henry White

14. MOTHER'S MAIDEN NAME Irene Jones

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
none	none	none	FATHER	SAME

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis, pulmonary — INTERVAL BETWEEN ONSET AND DEATH: 9½ hrs

DUE TO

(B) Cerebral Hemorrhage — 9½

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prematurity

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	—	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none	—	

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Aug 31, 1949, to Sept 1, 1949, *that I last saw the deceased alive on* August 31, 1949, *and that death occurred at* 1:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Claude T. Henderson M. D.	University Hosp.	9/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/2/1949	Mt Calvary	A. A. Co Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 2 - 1949	Huntington Williams, M.D.	Rayner Sanders	1412 E Preston St 160a

VS 150

0777838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

143

0777838 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Anthur Washington

2. DATE OF DEATH August 31 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) 16-4
D. STREET ADDRESS (If rural, give location) 1909 Harlem Ave.

Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
male	Colored		5-25-98	51		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter		Md.	

13. FATHER'S NAME Alexander Washington

14. MOTHER'S MAIDEN NAME Sarine Cuntra

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Arteriosclerosis with Cerebral Softening — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B)

DUE TO

(C) Carcinoma of Gingiva with Metastisis to Lung — 3 mos(?)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-26, 1949 to 8-31, 1949 *that I last saw the deceased alive on* 8-31, 1949, *and that death occurred at* 420 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Robert C. Hartmann M. D.	JOHNS HOPKINS HOSPITAL	8/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/3/49	Mt. Calvary	Anne Arundel Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
9-2-1949	Washington Williams, M.D.	Joseph G. Locke Jr.	1304 E. Central Ave

VS 150

45c

0778.39 0778.39

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 44 0778.39

TH NO.

NAME OF DECEASED (Type or Print) Joseph S. Barnett

2. DATE OF DEATH Sept. 1, 1949

PLACE OF DEATH: Baltimore City, Maryland 1403 Harford Ave

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1403 Harford Ave.

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-9
D. STREET ADDRESS (If rural, give location) 1403 Harford Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Col.	Widower	1877	Aged 72		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stevedore	Unemployed.	West River Md.	

13. FATHER'S NAME Samuel Barnett

14. MOTHER'S MAIDEN NAME Ellen Bias

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no or unknown)	

17. INFORMANT Vongella Bundy ADDRESS 1441 E. Monument St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cardio-renal disease — 1 year

DUE TO

(C) Ard High blood-pressure — Indefinite

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/22 1949 *to* 9/1 1949 *that I last saw the deceased alive on* 9-1-1949 *and that death occurred at* 3A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jas K. Blake M. D.	1603-N. Carolina	9-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	9/3/49	Mt. Calvary	Anne Arundel County Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
2-1949	Huntington Williams, M.D.	Robert L. Graef	1532 E. Monument St

VS 150

131a

8-40

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0778-40

TH NO. | Registered No.

NAME OF DECEASED (Type or Print) Bertie S Tapis

2. DATE OF DEATH Sept 1- 1949

PLACE OF DEATH: Baltimore City, Maryland 5232 Reisterstown Rd

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Md
b. COUNTY /
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28-1
d. STREET ADDRESS (If rural, give location) 5232 Reisterstown Rd.

Length of stay in Baltimore 70 yrs (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Dec 1867	81		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10a. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Md	US

13. FATHER'S NAME: Oliver A Stansbury

14. MOTHER'S MAIDEN NAME: Isabella Hare

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	—	Russell Hosfeld	3810 Woodbine Ave

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO Periodic enteritis — 20 yrs

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Very nervous? — Life?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
✓	✓	

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
✓	✓	✓

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
✓	✓	✓

22. *I hereby certify that I attended the deceased from* Feb 1 1944 *to* 9/1 1949, *that I last saw the deceased alive on* 9/1 1949, *and that death occurred at* 12 Noon *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Henry Russell M.D.	3902 Groveland Rd	9/1/1949

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 3-49	Druid Ridge	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 2 - 1949	Huntington Williams, M.D.	Frank W Seitz	814 W 36th St

VS 150

13B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0778:1

Registered No.

BTH NO. B.C.49-11145

NAME OF DECEASED (Type or Print): ROWE, RONALD

2. DATE OF DEATH: 9-2-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-2
D. STREET ADDRESS. (If rural, give location): 14 N. Pearl St. #1

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	3 June 1949	3 mos	3	29

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10a. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: GARNETT H. ROWE

14. MOTHER'S MAIDEN NAME: JESSIE LEWIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS: 14 N. Pearl St #1

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Diarrhea
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-1-49, 19__, *to* 9-2, 1949, *that I last saw the deceased alive on* 9-2, 1949, *and that death occurred at* 5 a *m., from the causes and on the date stated above.*

23A. SIGNATURE: E. J. Broaddus M. D.
23B. ADDRESS: University Hosp
23C. DATE SIGNED: 9-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-6-49
24C. NAME OF CEMETERY OR CREMATORY: St Peters
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 2 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilson & Dove ADDRESS: 1217 Park St

VS 150

119a

342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 Registered No. 077842

TH NO.

NAME OF DECEASED (Type or Print) Hooker T. Black

2. DATE OF DEATH Sept. 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland State Penitentiary Infirmary

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-3
D. STREET ADDRESS (If rural, give location) Maryland State Penitentiary Forrest & Eager St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (Last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
M	C	Married	1906?	42?				

9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10a. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Maryland	U.S.

13. FATHER'S NAME Not Known

14. MOTHER'S MAIDEN NAME Minnie Nokes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Minnie Walker ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive C.V. Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L. Kruger M.D.

23B CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Sept. 2 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Buried	9/5/49	Md. Memorial Cem.	Cloverton Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 2 - 1949	Huntington Williams M.D.	P. D. Hartman & Sons	Union Bridge & New Windsor Md.

HS 151 (937)

CERTIFICATE CORRECTED 10-6-49 ✓ 977843

977843 BALTIMORE CITY HEALTH DEPARTMENT 977843

TH NO. **CERTIFICATE OF DEATH** Registered No.

AME OF DECEASED (Type or Print) SADIE ARDELL BROWN BALLARD
~~SADIE ARDELL BROWN~~ (~~BALLARD~~ -information) 2. DATE OF DEATH Sept. 1, 1949

ACE OF DEATH: Baltimore City, Maryland ~~after death~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE DC B. COUNTY

ULL NAME OF HOSPITAL OR TITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Washington

D. STREET ADDRESS (If rural, give location) 51 Adams St.

ength of stay in Baltimore 37 days Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Col	DIVORCED	8/22/13	36		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10a. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ga.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Wood
14. MOTHER'S MAIDEN NAME Mattie Little

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown) known (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Records- US Marine Hospital, Balto, Md. ADDRESS

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of cervix — INTERVAL BETWEEN ONSET AND DEATH: About 3 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B)
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 26, 1949 *to* Sept. 1, 1949, *that I last saw the deceased alive on* Sept. 1, 1949, *and that death occurred at* 1:16P m., *from the causes and on the date stated above.*

23A. SIGNATURE John L. Wilson, Medical Director M. D.
23B. ADDRESS US Marine Hospital, Balto, Md.
23C. DATE SIGNED 9/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE 9/2/49
24C. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery
24D. LOCATION (City, town, or county) (State) Washington D.C.

DATE RECEIVED BY LOCAL REGISTRAR SEP 2 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Lanier Memorial Funeral Service ADDRESS Washington D.C.

VS 150

48a courtesy card #188.

847

G778-4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E812.0

TH NO. _____ Registered No. _____

NAME OF DECEASED (Type or Print) WILLIAM HARVEY GREISER

N-804.2

2. DATE OF DEATH September 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pasadena
D. STREET ADDRESS (If rural, give location) Fort Smallwood Road

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	3-22-1942	7		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____
10B. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Greiser
14. MOTHER'S MAIDEN NAME Rosalie Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____ (If yes, give war or dates of service) _____
16. SOCIAL SECURITY NO. _____

17. INFORMANT Mr. Robert Gibson, Pasadena, Md. ADDRESS

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushed head, with extensively

DUE TO Fractured skull and lacerated brain

(B) _____

DUE TO _____

(C) _____

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION _____ 19B. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) In front of 2616 Greenmount Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) September 1, 1949 Approx. 4 p. m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Ped. struck by auto-truck

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE George G. Merrill, M.D. per H. L. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED Sept. 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 9-3-49
24C. NAME OF CEMETERY OR CREMATORY LOUDON Pk.
24D. LOCATION (City, town, or county) (State) FREDERICK MD.

DATE RECEIVED BY LOCAL REGISTRAR 9/3/49
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR JOHN F. DENNIS, INC. ADDRESS 715 LIGHT ST

151

170C -30

845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

TH NO.

Registered No. 877845

NAME OF DECEASED (Type or Print): MINERVA CATHERINE McCONNELL

2. DATE OF DEATH: SEPT. 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4E. NORTH AVE

Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MD.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): TOWSON
D. STREET ADDRESS (If rural, give location): 607 ANNESLIE RD.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	W	MARRIED	JAN. 7, 1890	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTO. MD.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: OTHO J. ZITTLE
14. MOTHER'S MAIDEN NAME: JOSEPHINE BACHTELL

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: THOMAS E. McCONNELL ADDRESS: 607 ANNESLIE RD.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Thrombosis	10 minutes
DUE TO (B)	Hypertension Cardio Vascular disease.	10 years
DUE TO (C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 7, 1939 to Sept. 1, 1949 that I last saw the deceased alive on Aug. 9, 1949 and that death occurred at 9:20 A.m., from the causes and on the date stated above.

23A. SIGNATURE: H. A. Timmerello M. D.
23B. ADDRESS: 511 Medical Arts Bldg
23C. DATE SIGNED: Sept. 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 9-5-1949
24C. NAME OF CEMETERY OR CREMATORY: DRUID RIDGE
24D. LOCATION (City, town, or county) (State): PIKESVILLE MD

DATE RECEIVED BY LOCAL REGISTRAR: SEP 3 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. W. JENKINS & SONS CO.
ADDRESS: 4905 YORK RD.

VS 150

937

846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 0778-46

TH NO.

NAME OF DECEASED (Type or Print) CHARLES F. SCHMIDT

2. DATE OF DEATH SEPT. 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6000 BELLONA AVE EDGEWOOD NURSING HOME

Length of stay in Baltimore: Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTO.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) LONG GREEN
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	SINGLE	JUNE 8, 1871	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) LONG GREEN, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME JOHN SCHMIDT
14. MOTHER'S MAIDEN NAME REGINA SEIMULLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT CARL R. SCHMIDT ADDRESS 8626 ELKADER RD

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — Interval between onset and death: a. 4 y
DUE TO
(B) Chronic Nephritis — 4 mo
DUE TO
(C) Arteriosclerosis — ✓

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 29 *19*15 *to* Sept 1 *19*49 *that I last saw the deceased alive on* Sept 1 *19*49 *and that death occurred at* 1130a *m., from the causes and on the date stated above.*

23A. SIGNATURE H. C. Richardson M. D.
23B. ADDRESS 112 W. 20th St
23C. DATE SIGNED Sept. 3, 49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 9-3-1949
24C. NAME OF CEMETERY OR CREMATORY ST. JOHN'S
24D. LOCATION (City, town, or county) (State) BLENHEIM MD

DATE RECEIVED BY LOCAL REGISTRAR SEP 3 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR H. W. JENKINS & SONS CO.
ADDRESS 4905 YORK RD.

VS 150

121a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

F 10.3 — Registered No. 9778-47

TH NO.

NAME OF DECEASED (Type or Print): Henry Klein Sr. — N-863.0

2. DATE OF DEATH: Sept. 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 635 Augusta Ave. (S) 16-08

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	May 7, 1882	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bottling Dept Worker
10B. KIND OF BUSINESS OR INDUSTRY: Brewery

11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 216-01-4464

17. INFORMANT: Henry Klein Jr. — ADDRESS: 107 S. Bellefield Rd.

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute peritonitis, due to

DUE TO

(B) Rupture of intestine

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.): Brewery
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): American Brewery 1700 N. Gay St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug. 31, 1949 2:45 P.M.
21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? Struck in the abdomen with beer case

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-5-49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: SEP 3 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George Burley — ADDRESS: Baltimore Fayette St.

VS 151

195E

778:8 BALTIMORE CITY HEALTH DEPARTMENT 160.0 077848

TH NO. B.C. 49-18958 CERTIFICATE OF DEATH Registered No.

AME OF DECEASED e or Print) Pullara, Baby Boy | 2. DATE OF DEATH Sept 1, 1949

LACE OF DEATH: altimore City, Maryland

ULL NAME OF SPITAL OR TITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

Length of stay in Baltimore 9 hours (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 3505 Pelham Ave 26-03

EX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	single	Aug 31-49			9

. USUAL OCCUPATION (Give kind of ness during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	none	Maryland	

FATHER'S NAME Harry F. Pullara, Jr.

14. MOTHER'S MAIDEN NAME Mary Bresica

WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 9 hrs

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Small Intracranial Hemorrhage

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-31 1949 *to* 9-1, 1949, *that I last saw the deceased alive on* 9-1, 1949, *and that death occurred at* 8 05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Josephs M. D.	Mercy Hospital	9/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-3-49	St Peters	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 3 - 1949	Huntington Williams, M.D.	George A. Farley	Fulton ave & Fayette St.

VS 150

160a

Federal Ex

TH NO. Case Released to Hospital

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 077849

NAME OF DECEASED (Type or Print): Walter M. Davis

2. DATE OF DEATH: Sept. 2, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 5719 Kenmore Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married	July 15, 1887	62 yrs.		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Director Sales
10B. KIND OF BUSINESS OR INDUSTRY: McCormick & Co.
11. BIRTHPLACE (State or foreign country): Fredericksburg, Va.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Daniel M. Davis
14. MOTHER'S MAIDEN NAME: Sarah Bates

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL
ADDRESS:

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
Wm. G. Helfrich, M.D.
Per B S Fuller M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-2 1949 *to* 9-2 1949, *that I last saw the deceased alive on* 9-2 1949 *and that death occurred at* 3:45 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: W W S Butler M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 9-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/6/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 3 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150 To be approved by Med. Exam 9-4a

r Harold
06 Hartford Rd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

41 Registered No. 077850

TH NO.

NAME OF DECEASED (Type or Print) Eleanor E. Hardwick

2. DATE OF DEATH Aug 31, 49

PLACE OF DEATH: Baltimore City, Maryland Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gates Nursing Home

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2719 Hugo Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Fem	White	Married	May 2nd, 1874	75		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Maryland	

13. FATHER'S NAME Greenbury A. Pearce

14. MOTHER'S MAIDEN NAME Martha J. Simms

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Jesse C. Hardwick ADDRESS 2719 Hugo Av

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH ?

DUE TO

(B) Arteriosclerosis & Hypertension ?

DUE TO

(C) Cardio-vascular renal disease ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 29, 1949 *to* Aug 31, 1949, *that I last saw the deceased alive on* Aug 30, 1949, *and that death occurred at* 8:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. V. Harrold M. D.	4706 Harford Road	9-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	9/3/49	Woodh	Balto Co

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 3 - 1949	Huntington Williams, M.D.	Funeral of Buck	5305 Harford Rd

VS 150

131a

851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 977851

TH NO.

NAME OF DECEASED (Type or Print) WILLIAM CORN

2. DATE OF DEATH Sept 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital Redwood & Greene Sts

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Harford
C. CITY OR TOWN Bel Air (Rural)
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Col	W	Mar 4/70	79		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Harford Co
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Alex Corn
14. MOTHER'S MAIDEN NAME: Jennie Prigg
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic lymphatic leukemia — INTERVAL BETWEEN ONSET AND DEATH: 6 mo
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1949, to Sept 1, 1949, that I last saw the deceased alive on Sept 1, 1949, and that death occurred at 6 45 p.m., from the causes and on the date stated above.

23A. SIGNATURE David Auld M.D.
23B. ADDRESS Univ Hosp Balto, Md
23C. DATE SIGNED 9-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 5/49
24C. NAME OF CEMETERY OR CREMATORY: Clarks Chapel
24D. LOCATION-(City, town, or county) (State): Harford Co Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 3 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR ADDRESS: Joseph T. Foster Bel Air, Md.

VS 150

74a

852 — 0778 52

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3 50 Registered No.

TH NO.

NAME OF DECEASED (Type or Print): ZOFIA KOWALEWSKI

2. DATE OF DEATH: Sept 1st 1949

PLACE OF DEATH: Baltimore City, Maryland — 1100 Church St.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: 46 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1100 Church St 25-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Dec 1886	62	9	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown.
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown, give war or dates of service): NO
16. SOCIAL SECURITY NO.:

17. INFORMANT: Stephan Kowalewski ADDRESS: 1100 Church St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic pneumonia
DUE TO
(B) Paralysis Agitans
DUE TO
(C) Cerebral arteriosclerosis anemia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 5, 1947, *to* Sept 1, 1949 *that I last saw the deceased alive on* Sept 1, 1949 *and that death occurred at* 6:35 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Samuel Rubin M.D. M. D. | 23B. ADDRESS: 203 Cathedral | 23C. DATE SIGNED: 9/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 24B. DATE: SEPT. 5-49 | 24C. NAME OF CEMETERY OR CREMATORY: HOLY CROSS CEM | 24D. LOCATION (City, town, or county) (State): A A Co

DATE RECEIVED BY LOCAL REGISTRAR: SEP 3 - 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Bernard C Hanke | ADDRESS: 1216 E Mont St

VS 150

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353 JL - 15866

TH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Ward 1 — 077853 — Registered No.

AME OF DECEASED (e or Print) John Edward Kelly

2. DATE OF DEATH 8-25-49

LACE OF DEATH: Baltimore City, Maryland

ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore 19 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY 24-01
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1120 Hubbart St.

EX M | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH March 10, 1885 | 9. AGE (In years last birthday) 64 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

. USUAL OCCUPATION (Give kind of ork done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Balto., Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Martin Kelly

14. MOTHER'S MAIDEN NAME Catherine Mc Nulty

WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT B. C. H. Records, 4940 Eastern Ave. (ADDRESS)

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Probable Coronary Occlusion
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Incarcerated Inguinal Hernia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 9-18-41 | 19B. MAJOR FINDINGS OF OPERATION Removal of Cataract of Left Eye | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22 *I hereby certify that I attended the deceased from* 5-28-30, 19__, *to* Aug. 25, 19 49 *that I last saw the deceased alive on* Aug. 25, 1949, *and that death occurred at* 8.45 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE C. S. Rogers M. D. | 23B. ADDRESS 4940 Eastern Ave. | 23C. DATE SIGNED 9-3-1949

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 9-3-49 | 24C. NAME OF CEMETERY OR CREMATORY Sacred Heart | 24D. LOCATION (City, town, or county) (State) German Hill Rd

DATE RECEIVED BY LOCAL REGISTRAR SEP 3 - 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR J. J. Fahey & Sons | ADDRESS 1318 Light St

VS 150

OVER

937

CERTIFICATE CORRECTED 9-26-49

977854 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 977854

TH NO.

NAME OF DECEASED (Type or Print) William Aaron Porter

2. DATE OF DEATH Sept. 2, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S. Marine Hospital Baltimore 11, Maryland

Length of stay in Baltimore: Yrs. 0 Mos. 4 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Philadelphia
D. STREET ADDRESS (If rural, give location) 6100 Bostleton Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	Oct. 23, 1885	63		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oiler
10B. KIND OF BUSINESS OR INDUSTRY Seafaring
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Aaron Porter
14. MOTHER'S MAIDEN NAME Augusta Stoop
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Records, US Marine Hospital, Balto., Md. ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Stomach
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 29, 1949, *to* Sept. 2, 1949, *that I last saw the deceased alive on* Sept. 2, 1949, *and that death occurred at* 9:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS US Marine Hosp., Balto., Md.
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal
24B. DATE Sept 3/49
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, Town, or county) Phila Pa (State)

DATE RECEIVED BY LOCAL REGISTRAR SEP 4 1949
REGISTRAR'S SIGNATURE [signature]
25. FUNERAL DIRECTOR Philips Henry Sons, Inc. ADDRESS 1824

VS 150

46 B

077855

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 077855

H NO. 077855

AME OF DECEASED (or Print) Lee T Ebaugh

2. DATE OF DEATH September 3 1949

LACE OF DEATH: altimore City, Maryland

ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) Ventnor Lodge ~~Chapelgate Lane~~

ength of stay in Baltimore 9 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural near Freeland.
D. STREET ADDRESS (If rural, give location) 2 mi North of Freeland.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years. Last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	White.	Widowed.	March 20 1865	84		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician.	Street Cars.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME Elisah Ebaugh.

14. MOTHER'S MAIDEN NAME Catherine Hicks.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Walter Shaul	Freeland, Md. RD

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Auricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Chronic Myocarditis + Myocardial degeneration — ?

DUE TO

(C) Generalized arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Secondary Anemia — 1 year

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 19, 19 49 to Sept. , 19 49, that I last saw the deceased alive on Sept 3, 19 49 and that death occurred at 5:20 P. m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Melvin N. Borden M. D.	2030 W. Fayette St	9/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 6 1949	Mt. Zion Cem.	Freeland, Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 4 - 1949	Lyon Williams, M.D.	J. Jacob Hartenstein	New Freedom, Pa. 93D

VS 450

077856

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V-18 077856

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) GEORGE THOMAS LINTHICUM

2. DATE OF DEATH 9-3-49

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

Length of stay in Baltimore 38 years Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 711 St. John Pl. 7-13

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	Oct 1, 1887	61		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Fidelity & Deposit Co.	Maryland (West River)	America

13. FATHER'S NAME Thomas F. Linthicum

14. MOTHER'S MAIDEN NAME Margaret Beal

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Specify yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	World War I	218-09-3821	Mrs. Mary C. F. Linthicum	Balto. Md.

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Multiple Pulmonary emboli	22 hours
	DUE TO (B) phlebitis, Pelvic veins	3 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) operative Procedure	9 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Benign	

19A. DATE OF OPERATION 9-25-49 | 19B. MAJOR FINDINGS OF OPERATION Tumor mass arising from region of right lobe of prostate | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-15, 1949, to 9-2, 1949 *that I last saw the deceased alive on* 9-2, 1949 *and that death occurred at* 2:24 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David H. Smith M. D.	Union Memorial Hospital	9-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept-5-1949	Christ Churchyard, Owensville, A. A. Co., Maryland	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 4 - 1949	Thurlington Williams, M.D.	Stewart & Mowen Co.	108 W. North Ave. Baltimore #1, Md.

VS 460

137a

0778.57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0778.57

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Louise Schulz

2. DATE OF DEATH Sept 3-1949

PLACE OF DEATH: Baltimore City, Maryland 2823 Fleetwood Ave

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ✓

Length of stay in Baltimore 40 yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 2823 Fleetwood Ave B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 27-07 Balto Md

D. STREET ADDRESS (If rural, give location) 2823 Fleetwood

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
F	W	Widowed	1-16-1858	91	7	18

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home

10B. KIND OF BUSINESS OR INDUSTRY ✓

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Franz Kuhl

14. MOTHER'S MAIDEN NAME ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) No (If yes, give war or dates of service) ✓

16. SOCIAL SECURITY NO. ✓

17. INFORMANT Mrs Ernest Clark ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease

DUE TO

(B) Senility -

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 26, 1949 *to* Sept 3, 1949 *that I last saw the deceased alive on* Aug 26, 1949 *and that death occurred at* 6:30 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE H P Lewis M. D.

23B. ADDRESS 2400 Eutaw Ave

23C. DATE SIGNED 9/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9/6/49

24C. NAME OF CEMETERY OR CREMATORY Balto

24D. LOCATION (City, town, or county) Balto (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 4 - 1949

REGISTRAR'S SIGNATURE Hamilton Williams M.D.

25. FUNERAL DIRECTOR Leonard J Rinck ADDRESS 1305 Hanford Ave

VS 150

93D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33

Registered No. 077858

TH NO. 077858

NAME OF DECEASED (Type or Print): ELIZABETH B. WARD

2. DATE OF DEATH: 9/3/49

PLACE OF DEATH: Baltimore City, Maryland 1213 Light St

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hos

Length of stay in Baltimore: Yrs. 60 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 1213 Light Balto Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 24-13
D. STREET ADDRESS (If rural, give location): 1213 Light St. Balto Md

3. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W.	Single	8/26/1858	91		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10a. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Registered Nurse	Nursing	N. Va	USA

13. FATHER'S NAME: John Ward

14. MOTHER'S MAIDEN NAME: Lutz & McCormick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (No or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT: Miss Sally Ward ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Fracture femur - Right - old.

DUE TO

(C) General Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John A. Sarno M. D.	So. Balt. Gen. Hosp.	Sept 3 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/6/49	Cathedral	100 Fremont Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 4 - 1949	Williams, M.D. Registrar	J. J. Fahey & Sons	1316 Light St

VS 150

83a

Med. Exam. Case
077859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

077859 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) FRANK Dombrowski

2. DATE OF DEATH SEP 2 - 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2-01
D. STREET ADDRESS (If rural, give location) 238 S. Chapel, St.

Length of stay in Baltimore Balto. Md. Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	Married	Jan 15 - 1885	64		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ship sealer	Boats	Poland Balto Md	U.S.A.

13. FATHER'S NAME Michael Dombrowski

14. MOTHER'S MAIDEN NAME Josephine Lentz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		212-10-8056

17. INFORMANT. JOHNS HOPKINS HOSPITAL ADDRESS

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heart Attack — INTERVAL BETWEEN ONSET AND DEATH: circum 36 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary occlusion

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
Edward L Boyd
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE - (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip J. Wagley M. D.	JOHNS HOPKINS HOSPITAL	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sep. 4-1949	Holy Rosary	Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 4 - 1949	Hunter Williams, M.D.	Wm. S. Fjaltowski	2007 Eastern Ave

VS 150

Released to Hospital 9/4/49, be approved

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H NO. 077800 — Registered No. 44 ✓ 077800

NAME OF DECEASED (Type or Print): Ralph Dieter Cook

2. DATE OF DEATH: Sept. 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2028 McCulloh St.

Length of stay in Baltimore: 48 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03
D. STREET ADDRESS (If rural, give location): 2028 McCulloh St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Sept. 1, 1874	74		

10. USUAL OCCUPATION (Give kind of one doing most of working life, even if retired): Teacher
10a. KIND OF BUSINESS OR INDUSTRY: Public school
11. BIRTHPLACE (State or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John L. Cook
14. MOTHER'S MAIDEN NAME: Ellen Agpro
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Vivian L. Cook — ADDRESS: 2028 McCulloh St

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage with — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO left hemiplegia

(B) Arteriosclerotic cardio-vascular — 2 years
DUE TO renal disease

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 22 Aug., 1949, to 1 Sept, 1949, *that I last saw the deceased alive on* 1 Sept, 1949, *and that death occurred at* 8 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: James D. Carr M.D.
23B. ADDRESS: 1427 Madison Ave
23C. DATE SIGNED: 1 Sept 1949

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4 Sept 1949
24C. NAME OF CEMETERY OR CREMATORY: Harmony Cem.
24D. LOCATION (City, town, or county) (State): Wash. D.C.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 6 1949
REGISTRAR'S SIGNATURE: Thurston Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home — ADDRESS: 1681 Druid Hill Ave

131a

CERTIFICATE CORRECTED 9-8-49 X

077831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

077831

Registered No.

TH NO.

AME OF DECEASED (e or Print) David W. Kumpf

2. DATE OF DEATH September 3, 1949

LACE OF DEATH: Baltimore City, Maryland

ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Pa. B. COUNTY Franklin

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Williamson

D. STREET ADDRESS (If rural, give location)

EX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
ale	White	Widowed	3-2-1873	76		

USUAL OCCUPATION (Give kind of one during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer (Retired)		Pa.	U.S.A.

FATHER'S NAME Christian Kumpf

14. MOTHER'S MAIDEN NAME Elizabeth Keyser

WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None		JOHNS HOPKINS HOSPITAL	

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary sclerosis & thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 min

DUE TO

(B) Arteriosclerotic heart disease

DUE TO

(C) Benign prostatic hypertrophy

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9/2/49	Benign Prostatic hypertrophy	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-29, 1949, *to* 9-3, 1949, *that I last saw the deceased alive on* 9-3, 1949, *and that death occurred at* 8:41 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John L. Sheppard M. D.	JOHNS HOPKINS HOSPITAL	9/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/6/49	Greencastle Cemetery	Greencastle, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 4 1949	Registrar for Williamson, Md.	Wm. J. Tickner & Sons, Inc.	North & Pa. Aves., Balto. 17, Md.

VS 150

137a

G77862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

File No. G77862 Registered No.

TH NO.

AME OF DECEASED e or Print) JOHN SCHILLER

2. DATE OF DEATH Sept. 2, 1949

LACE OF DEATH: altimore City, Maryland BALTIMORE

ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) 3 S. Ellwood Ave

Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 3 S. Ellwood Ave

EX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
ale	White	Married	Aug. 13, 1885	64		

USUAL OCCUPATION (Give kind of ne during most of working life, even if retired) surance Salesman

10a. KIND OF BUSINESS OR INDUSTRY Insurance

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

FATHER'S NAME Frank Schiller

14. MOTHER'S MAIDEN NAME Anna Scholtz

WAS DECEASED EVER IN U. S. ARMED FORCES? o or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 577-07-1831

17. INFORMANT Mrs Lottie Schiller ADDRESS 3 S. Ellwood Ave

CAUSE OF DEATH

18.

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis

DUE TO

(B) Coronary arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-24, 1947 *to* 9-2, 1949, *that I last saw the deceased alive on* 9-2, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE John J Gould M. D. | 23B. ADDRESS 141 N Castle | 23C. DATE SIGNED 9-3-49.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Sept. 5 1949 | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | 24D. LOCATION (City, town, or county) (State) Balto.

DATE RECEIVED BY LOCAL REGISTRAR SEP 4 - 1949 | REGISTRAR'S SIGNATURE [illegible] | 25. FUNERAL DIRECTOR John A. Moran | ADDRESS 3000 E Balto St.

VS 150

94a

077863

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

077863 Registered No.

TH NO.

AME OF DECEASED e or Print): Louise Greimes

2. DATE OF DEATH: Sept. 2-1949

LACE OF DEATH: Baltimore City, Maryland 3001 Walbrook ave

ULL NAME OF SPITAL OR TITUTION (If not in hospital or institution, give street address or location): —

Length of stay in Baltimore: 83 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 3001 Walbrook ave 15-16

EX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	White	Widow	Mch. 20-1866	83		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	at Home	Baltimore Md	

13. FATHER'S NAME: William Stehman

14. MOTHER'S MAIDEN NAME: ? Bauer

WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Virginia C Greimes	2901 Walbrook ave

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute hepatitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Pneumonia bronchial — 1 week

DUE TO

(C) Arteriosclerotic Cardio-Vascular disease — years?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
—		

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1949 *to* Sept. 2, 1949, *that I last saw the deceased alive on* Sept 2, 1949 *and that death occurred at* 3 3/5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Daniel F Johnson M. D.	2135 Guilford Ave & Pk Ave	9/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 5-49	Druid Ridge Cem	Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
9-1-1949	[illegible] for Millicent Mills	G Howard Strong	3207 W North ave

VS 150

937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(17803) 17804

TH NO. B.C.49-18387 Registered No.

AME OF DECEASED (Type or Print): Herwitz, Baby Girl

2. DATE OF DEATH: 2 Sept 1949

LACE OF DEATH: Baltimore City, Maryland

ULL NAME OF SPITAL OR TITUTION (If not in hospital or institution, give street address or location): Sinai

Length of stay in Baltimore: 2 Days (Yrs. Mos. struck out)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 711 Laurel Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Single	31 August 1948	—	—	2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Balto Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rubin Herwitz

14. MOTHER'S MAIDEN NAME: Bernice Motzno

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Rubin Herwitz ADDRESS: 711 Laurel Ave

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Atelectasis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 31 August 1949 *to* 2 September 1949 *that I last saw the deceased alive on* 2 Sept. 1949 *and that death occurred at* 6:27 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE: Sidney Green M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 3 Sept 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-4-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 4 1949
REGISTRAR'S SIGNATURE: Registrar for Baltimore, Md.
25. FUNERAL DIRECTOR: Jack Rewis Inc
ADDRESS: 2100 Eutaw Pl

159

077865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

150.0

077865

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) MICHAEL GREENBERG

2. DATE OF DEATH 9-3-49

PLACE OF DEATH: Baltimore City, Maryland 3706 Nortonia Rd

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Mount

Length of stay in Baltimore 60 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3-21-
D. STREET ADDRESS (If rural, give location) 41 So Bond St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	married	?	90				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Maker
10B. KIND OF BUSINESS OR INDUSTRY self
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Not Known
14. MOTHER'S MAIDEN NAME Not Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Henry Greenberg ADDRESS 342 Royce Ave

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs
DUE TO
(B) arteriosclerosis — 4 yrs
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/1 *,* 1949 *to* 9/3 *,* 1949*, that I last saw the deceased alive on* 9/2 *,* 1949*, and that death occurred at* 7 A *m., from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS 1440 E Balto
23C. DATE SIGNED 9/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9-4-49
24C. NAME OF CEMETERY OR CREMATORY Rosedale
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 4 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eutaw Pl

97

077866

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

077866 Registered No. 62

TH NO. 077866

NAME OF DECEASED (Type or Print) WILLIAM H. McKINNELL

2. DATE OF DEATH Sept. 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN Essex (If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location) 18 A. Fenway

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 hours: Hours / Min.
Male	White	Married	Aug. 4, 1921	28		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10a. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Flight Engineer	Glenn L. Martin	Maryland	U.S.A.

13. FATHER'S NAME: Henry McKinnell

14. MOTHER'S MAIDEN NAME: Lillie May Zenker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Lillie May McKinnell ADDRESS

CAUSE OF DEATH

16. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation due to inhalation of gasoline fumes

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Industrial

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Glenn L. Martin Airport, Balto. Co.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): September 1, 1949 ? p.m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Inhalation of gas fumes from airplane exhaust

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

23a. SIGNATURE: George G. Merrill M.D.

23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐

23c. DATE SIGNED: 9/2/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/6/49

24c. NAME OF CEMETERY OR CREMATORY: U.S. National

24d. LOCATION (City, town or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 5 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Edward J. MacNabb & Son

ADDRESS: 175 X Catonsville Md

0778-47 X 0778-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

TH NO. BC-49-19411 Registered No.

NAME OF DECEASED (Type or Print) Baby Girl Myers

2. DATE OF DEATH Sept. 4, 1949

PLACE OF DEATH: Baltimore City, Maryland BALTIMORE

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hosp.

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY Prince Georges
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RIVERDALE
D. STREET ADDRESS (If rural, give location) 4705 W ELLS PK WAY

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Infant	Sept. 4, 1949	4hrs. 20 min			4	20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME WALTER MYERS
14. MOTHER'S MAIDEN NAME Nancy HESS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Premature - 22 wks.
DUE TO
(B) Premature Separation Placenta

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 4, 1949 *to* Sept. 4, 1949, *that I last saw the deceased alive on* Sept. 4, 1949, *and that death occurred at* 10:00 Am., *from the causes and on the date stated above.*

23A. SIGNATURE Dr. Schaefler M. D.
23B. ADDRESS Bon Secours Hosp.
23C. DATE SIGNED 9/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9/6/49
24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem
24D. LOCATION (City, Town, or County) (State) Woodlawn Cem

DATE RECEIVED BY LOCAL REGISTRAR SEP 5 - 1949
REGISTRAR'S SIGNATURE [illegible], Md.
25. FUNERAL DIRECTOR Charles P Towell
ADDRESS 2427 E. Monument Ave

VS 150

160 c

077808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

077808

Registered No.

TH NO. B.C.H.-05331

NAME OF DECEASED (Type or Print) Lynda Janet Freedman

2. DATE OF DEATH September 5, 1949

PLACE OF DEATH: Baltimore City, Maryland 3808 Woodhaven Ave

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ~~3808 Woodhaven Ave~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 3421 Reisterstown Road

Length of stay in Baltimore: Yrs. Life Mos. Days

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Child	July 20, 1944	5	1 / 16	

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore Md	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Aaron Freedman	Natalie Toor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Aaron Freedman	3421 Reisterstown Road

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma of the adrenal — Interval between onset and death: 4 yrs
DUE TO
(B) Carcinomatosis — 1½ yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cardiac failure — 2-3 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from September, 1946 to Sept 5, 1949, that I last saw the deceased alive on Sept 4, 1949, and that death occurred at 4:30a m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Lillian W Rosenthal M. D.	1739 Eutaw Pl 17	Sept 5, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 5, 1949	Beth Tfiloh Cemetery	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 5 1949	Huntington Williams, M.D.	Sol Levinson & Bros	1126 W North Ave

VS 150

55a

077869 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

TH NO. 077869 Registered No. 077869

NAME OF DECEASED (Type or Print): Clara E. Dixon

2. DATE OF DEATH: 9/7/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 729 Brantley St

Length of stay in Baltimore: 4 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 16-08
D. STREET ADDRESS (If rural, give location): 729 Brantley St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W		Feb 8 1862	87		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George W. Layman
14. MOTHER'S MAIDEN NAME: Sophia R. Favorite
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. John E. Clabaugh ADDRESS: 729 Brantley St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C.V disease
DUE TO
ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23a. SIGNATURE: P. L. Sulinski M.D.
23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23c. DATE SIGNED: 9/7/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9.7.49
24c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24d. LOCATION (City, town or county) (State): Frederick Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 5 1949
REGISTRAR'S SIGNATURE: Evelyn Williams, M.D.
25. FUNERAL DIRECTOR: M. R. Eichelberger & Son
ADDRESS: Frederick Md.

93D

077870 BALTIMORE CITY HEALTH DEPARTMENT 077870 70

CERTIFICATE OF DEATH

331

TH NO. Registered No.

NAME OF DECEASED (or Print) ANNIE IRENE KNIGHT

2. DATE OF DEATH Sept 3. 1949

PLACE OF DEATH: Baltimore City, Maryland 2751 Rayner Ave

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2751 Rayner Ave

Length of stay in Baltimore 79 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2751 Rayner Ave 11-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Mar 5. 1870	79		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work

10b. KIND OF BUSINESS OR INDUSTRY at Home

11. BIRTHPLACE (State or foreign country) Baltimore Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Murphy

14. MOTHER'S MAIDEN NAME Johanna Hennessy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) / (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Elizabeth R. O'Neill ADDRESS 2751 Rayner Ave

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 9 days

DUE TO

(B) arteriosclerosis — 1 yr

DUE TO

(C) Chr. Nephritis — 1 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS. IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 25 *1949, to* Sept 3rd *, 1949 that I last saw the deceased alive on* Sept 2 *, 1949 and that death occurred at* 1.05 P *m., from the causes and on the date stated above.*

23A. SIGNATURE M. McDermott M. D. M. D.

23B. ADDRESS 1136 Park Ave

23C. DATE SIGNED 9/3/49.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Sept 6. 1949

24C. NAME OF CEMETERY OR CREMATORY New Cathedral

24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 5-1949

REGISTRAR'S SIGNATURE Lexington Williams, M.D.

25. FUNERAL DIRECTOR John J. Cowan & Son

ADDRESS Hollins St 1319

VS-150

✓ 077871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54

Registered No.

TH NO. 077871

NAME OF DECEASED (or Print) Cecelia H. Fuld

2. DATE OF DEATH 1 September 1949

PLACE OF DEATH: Baltimore City, Maryland Marlboro Apts.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Marlboro Apartments

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore
B. COUNTY Maryland
C. CITY OR TOWN Baltimore
(If outside corporate limits, write RURAL and give township) Maryland
D. STREET ADDRESS (If rural, give location) 1900 Eutaw Place 14-07

Length of stay in Baltimore 78 years (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Single	August 26, 1871	78yrs.		6		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Buyer	Hoschilds Kohn Co.	Baltimore	U.S.A.

13. FATHER'S NAME: Issac Fuld

14. MOTHER'S MAIDEN NAME: Hannah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		None	Harry Baer	4304 Liberty Heights Ave

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Ca. — INTERVAL BETWEEN ONSET AND DEATH: 6 & 10 Mo.

DUE TO

(B) Carcinoma of Rectum — 15 Mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-5 *,* 1949 *to* 9-1 *,* 1949 *, that I last saw the deceased alive on* 9-1- 1949 *. and that death occurred at* 2-P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
A. A. Elser M. D.	Temple Gardens Apt.	9-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	9/5/49	Laudon Park	Frederick Avenue Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 5-1949	Huntington Williams, M.D.	David Sondheim & Son DAVID SONDHEIM	1908 Eutaw Place 461

VS 150

✓ 571.0

077872

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

077872 72
Registered No.

TH NO. B.C. 48-15267

NAME OF DECEASED (Type or Print): Doris Marie Rowe

2. DATE OF DEATH: Sept 4, 1949

PLACE OF DEATH: Baltimore City, Maryland — Mercy Hospital

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-0 ✓
D. STREET ADDRESS (If rural, give location): 14 N Pearl St.

Length of stay in Baltimore: Life (Yrs. Mos. Days)

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Single	July 14, 1948	13 mos				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? U.S. ✓
13. FATHER'S NAME: Garnett H. Rowe
14. MOTHER'S MAIDEN NAME: Janie B. Lewis ✓
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Garnett H. Rowe — ADDRESS: 14 N. Pearl St.

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diarrhea, Acidosis
DUE TO Malnutrition
Probable bacillary infection

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 days

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 2, 1947, *to* Sept 4, 1947, *that I last saw the deceased alive on* Sept 4, 1947, *and that death occurred at* 12¹⁵ *m., from the causes and on the date stated above.*

23A. SIGNATURE: H. Rasken M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 9/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/6/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Lebanon
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: 5-VS-1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Nelson M. Cohen Inc
ADDRESS: 1210 E. Lanvale St

119a

0778?3 ✓ 0778?3

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Clarinda B. Barker

2. DATE OF DEATH 9-3-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-05
D. STREET ADDRESS (If rural, give location) 1210 St. Paul St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	Feb 5, 1865	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Shelby County, Ill
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME (Unknown) Beckett
14. MOTHER'S MAIDEN NAME (Unknown) Shelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None

17. INFORMANT Miss R. Joyce Barker ADDRESS 1710 St. Paul St.

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

(B) Arteriosclerosis Generalized Moderate

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Senility

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Robert B. McAdden M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED 9-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24B. DATE 9/5/49
24C. NAME OF CEMETERY OR CREMATORY Green Mount
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 5 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR William Cook, Inc., ADDRESS 1217 St. Paul St.

VS 151

937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

TH NO. 077874 — Registered No. 077874

NAME OF DECEASED (Type or Print): Clara M. Bush

12. DATE OF DEATH: Sept.3/49

PLACE OF DEATH: Baltimore City, Maryland 5080 Orville Ave.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): --

Length of stay in Baltimore: 65 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 5080 Orville Ave.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location): 5080 Orville Ave. 26-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widow	Jan.22,187[illegible]	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --
10B. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): W.Va.
12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME: ---Charlton
14. MOTHER'S MAIDEN NAME: ------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): -- / ---
16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Mr.Ellwood Bush — ADDRESS: 5080 Orville Ave.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Rectum
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1949, to Sept 3, 1949 *that I last saw the deceased alive on* Sept 2, 1949, *and that death occurred at* 2:55 *m., from the causes and on the date stated above.*

23A. SIGNATURE M. D. | 23B. ADDRESS 3409 Ed | 23C. DATE SIGNED 9/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Sept.5/49 | 24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem. | 24D. LOCATION (City, town, county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 5 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Philip Henrig Sons | ADDRESS: 2024 Orleans St.

467

JL - 131524 0778875 BALTIMORE CITY HEALTH DEPARTMENT 43 0778875

CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) William Boardley

2. DATE OF DEATH 9-1-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore 40 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1439 N. Fulton Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Negro	Married	March 19, 1899	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Fla.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT B. C. H. Records, ADDRESS 4940 Eastern Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident
DUE TO
(B) Hypertensive Cardiovascular Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CHIEF OR ASST. MEDICAL EXAMINER, M. D.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 1, 1949 *to* Sept. 1, 1949 *that I last saw the deceased alive on* Sept. 1, 1949, *and that death occurred at* 3.50 PM, *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D. | 23B. ADDRESS 4940 Eastern Ave. | 23C. DATE SIGNED 9-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-5-49 | 24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Ct | 24D. LOCATION (City, town, or county) (State) A.A.Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 5 1949 | REGISTRAR'S SIGNATURE [signature], M.D. | 25. FUNERAL DIRECTOR J. L. Brown & Son | 108 ADDRESS W. Montgomery ST

To Be approved by Medical Examiner

93D

0778?6 — BALTIMORE CITY HEALTH DEPARTMENT — 0778?6

CERTIFICATE OF DEATH

TH NO. — Registered No.

NAME OF DECEASED (Type or Print): DELIA WELSH

2. DATE OF DEATH: Sept. 2, 1949

PLACE OF DEATH: Baltimore City, Maryland BALTIMORE

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 414 N. LINWOOD AVE

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~Maryland~~ Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 414 N. Linwood Ave

5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Mar. 21, 1873
9. AGE (In years last birthday): 76
If under 1 year: Months / Days
If under 24 hours: Hours / Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

FATHER'S NAME: Peter Welsh
14. MOTHER'S MAIDEN NAME: Bridget Hanley

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Mary A. Newlent — ADDRESS: 414 N. Linwood

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
DUE TO
(B) Arteriosclerosis, generalized disease — 2 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/27/ 1949 *to* 9/2/ 1949, *that I last saw the deceased alive on* 9/2/ 1949, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Benj. B. Moses M. D.
23B. ADDRESS: 448 N. Fulton Ave
23C. DATE SIGNED: 9/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: Sept. 6, 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Moran
ADDRESS: 3000 E. Baltimore Blvd. Md.

937

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

RTH NO. Registered No.

NAME OF DECEASED (Type or Print): Barbara R. Smith

2. DATE OF DEATH: 9/3/49

PLACE OF DEATH: Baltimore City, Maryland BALTIMORE

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 832 W. Baltimore St

Length of stay in Baltimore: 31 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 16-01
D. STREET ADDRESS (If rural, give location): 832 W. Baltimore St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
F	W	Widowed	7-3-1871	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Penna.	

13. FATHER'S NAME: Conrad J. Schmidt

14. MOTHER'S MAIDEN NAME: Roselia Doll

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
			Louis J. Smith	7308 Heintz Ave

18 CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C.V. disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B)
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
C. J. Tribuncka M.D.		9/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	9-7-49	Oaklawn	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
9-5-1949	Huntington Williams, M.D.	John A. Moran	3000 E. Balt. St.

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077878 ✓ 077878

TH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

AME OF DECEASED e or Print): Nicholas Takas

2. DATE OF DEATH: Aug 26-49

LACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

2855 Woodbrook Ave

ULL NAME OF SPITAL OR TITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md 12-14

Length of stay in Baltimore: 40 YRS (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 2855 Woodbrook Ave

EX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	Married	March 21-1892	57		

. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker	Bakery	Greece	[redacted]

FATHER'S NAME: Constantine Takas

14. MOTHER'S MAIDEN NAME: Anesto

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no or unknown)	213-12-8568	George Stratakes	2855 Woodbrook

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Myocardial Infarction	30 min.
DUE TO		
(B)	Arteriosclerotic heart disease.	
DUE TO		
(C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 26, 1949, *to* Aug 26, 1949, *that I last saw the deceased alive on* Aug 26, 1949, *and that death occurred at* 10:10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Nathan J Van Lill M. D.	2843 St Paul St	8-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Aug 29-49	Greek Orthodox	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 5 1949	[redacted]	Sambros Funeral Home Inc.	930 440 E. North Ave.

VS 15

TH NO. 077879

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

58 077879 Registered No.

NAME OF DECEASED (Type or Print)
JOHN LOUIS CARNEY

2. DATE OF DEATH SEPTEMBER 3 194

PLACE OF DEATH: Baltimore City, Maryland 1651 CARSWELL STREET

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
NONE

Length of stay in Baltimore LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE BALTIMORE CITY B. COUNTY MARYLAND
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE CITY.
D. STREET ADDRESS (If rural, give location) 1651 CARSWELL STREET.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Aug. 8, 1904	45		25

9-07

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10a. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Coffee Representative	Western Maryland R.R.	Baltimore	U.S.

13. FATHER'S NAME Edward S. Carney Jr.
14. MOTHER'S MAIDEN NAME Anna Adolph

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Catherine Reed Carney	1651 Carswell St.

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) HYPERTROPHIC CIRRHOSIS LIVER	1948.
	DUE TO (B) CHRONIC PANCREATITIS	1948.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	NONE	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
DECEMBER 22 1948	HYPERTHROPIC CIRRHOSIS OF LIVER	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* MAY 20 1948 *to* SEPT 3, 1949 *that I last saw the deceased alive on* SEPT 3 1949, *and that death occurred at* 6.10 P. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Charles P. Clautice	3013 ST. PAUL STREET	SEPT 3 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-6-49	New Cathedral	Old Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 5 1949	Huntington Williams, M.D.	J. Walter Conklin	2343 Harford Rd.

124B

077880

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

077880

TH NO.

Registered No.

NAME OF DECEASED (Type or Print) Armenta Taylor

2. DATE OF DEATH Sept. 4, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore
(If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) Redwood and Greene Sts. 4-01

Length of stay in Baltimore: 20 Yrs. Mos. Days

SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single

8. DATE OF BIRTH 3/10/1910

9. AGE (In years last birthday) 39
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Supt. of Nurses

10B. KIND OF BUSINESS OR INDUSTRY Hospital

11. BIRTHPLACE (State or foreign country) Georgia

12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME Harry Taylor

14. MOTHER'S MAIDEN NAME Sue Waughter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT University Hospital ADDRESS

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory failure
DUE TO
(B) Carcinomatosis, generalized
DUE TO
(C) Primary carcinoma, breast

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1, 1949, to Sept. 4, 1949, that I last saw the deceased alive on Sept. 4, 1949, and that death occurred at 7:25 A.m., from the causes and on the date stated above.

23A. SIGNATURE Fred R. McClement Jr. M. D.

23B. ADDRESS University Hospital

23C. DATE SIGNED 9/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal

24B. DATE 9/4/49

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State) Red Lion Pa.

DATE RECEIVED BY LOCAL REGISTRAR SEP 5 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm. J. Tickner & Sons

ADDRESS North & Pa. Aves

50

Geo. W. Manley

~~G77831~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77831 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) George W. Manly

2. DATE OF DEATH Sept. 3, 1949

PLACE OF DEATH: Baltimore City, Maryland 3307 Egerton Rd.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3307 Egerton Road

Length of stay in Baltimore: Yrs. Life; Mos.; Days

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
ale	White	Married	Jan. 17, 1873	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
yyer Self	Retired	Baltimore, Md.	

FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Stephen B. Manly	Balto. Md.	Mary E. Hurdle	Balto. Md.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Spanish American	?	Mrs. Minnie Y. Manly	3307 Egerton Road

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-1 1944 *to* 9-3 1949, *that I last saw the deceased alive on* 9-3 1949, *and that death occurred at* 6 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Redmund Levin M. D.	3400 Hilton Rd	9/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/6/49	Loudon Park Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 5 1949	Huntington Williams, M.D.	William J. Tickner & Sons, Inc.	Balto. Md.

92D

7882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1949 Registered No. 7882

TH NO.

NAME OF DECEASED (Type or Print): Susan Hellen

2. DATE OF DEATH: 9/29/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp

Length of stay in Baltimore: 27 hrs (Years, Months, Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto #23 Essex
D. STREET ADDRESS (If rural, give location): 811 Brunswick Rd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White		9/28/49		27

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Victor Paul Hellen

14. MOTHER'S MAIDEN NAME: Virchia Eugene Mc Kinney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mother ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral Atelectasis

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/28, 1949, *to* 9/29, 1949 *that I last saw the deceased alive on* 9/29, 1949, *and that death occurred at* 9:55 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Daniel Lewis Silverstein M. D.

23B. ADDRESS: Mt Baltimore Gen'l Hosp.

23C. DATE SIGNED: 9/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State): OCT 3 1949

DATE RECEIVED BY LOCAL REGISTRAR: OCT 5 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Commissioner of Health ADDRESS

VS 150

159

883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 76 ✓

077883 Registered No.

TH NO. D.C. 49-12090

NAME OF DECEASED (Type or Print) Baby Spencer

2. DATE OF DEATH 6-16-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

Length of stay in Baltimore 1 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1620 W Fayette St. 1902

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Negro		6-16-49		1	2 30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Nathaniel Spencer
14. MOTHER'S MAIDEN NAME Edith Kent
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital Anelectasis
DUE TO
(B) Weak Premature
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
A
B

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/16 1949 *to* 6/16 1949, *that I last saw the deceased alive on* 6/16 1949, *and that death occurred at* 1100 p *m., from the causes and on the date stated above.*

23A. SIGNATURE Herbert Crowley M. D.
23B. ADDRESS Provident Hosp.
23C. DATE SIGNED 7/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY Westwood
24D. LOCATION (City, town, or county) Baltimore (State)

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

159

384 ✓X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10 4-0 Registered No. 077884

TH NO.

NAME OF DECEASED (Type or Print) EUGENE BLACKFORD

2. DATE OF DEATH 5 SEPT 49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

Length of stay in Baltimore 76 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MD.
B. COUNTY BALT.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BIRDSVILLE 8
D. STREET ADDRESS (If rural, give location) OLD COURT ROAD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	S	17 SEPT 1872	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (RETIRED) ? FARMER
10B. KIND OF BUSINESS OR INDUSTRY SELF
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME EUGENE BLACKFORD
14. MOTHER'S MAIDEN NAME REBECCA GORDON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) UNK (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT MRS. EMILY B. POULTNEY SISTER ADDRESS SAME

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute lymphatic leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

(B)

DUE TO

(C)

II ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. atelectasis of right lower lobe — 24 hours

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4 SEPT, 1949, *to* 5 SEPT, 1949, *that I last saw the deceased alive on* 5 SEPT, 1949, *and that death occurred at* 9:50 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE W. F. Cox 3d M. D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 9/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept 7/49
24C. NAME OF CEMETERY OR CREMATORY St Thomas
24D. LOCATION (City, town, or county) (State) Garrison Forest Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 6 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Henry J. Jenkins & Son Co ADDRESS 4905 York Rd.

VS 150

74a

7885

TH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

80.0

077885 Registered No.

NAME OF DECEASED (Type or Print) Edith Ross

2. DATE OF DEATH 9-4-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto, Md. 25-33
D. STREET ADDRESS (If rural, give location) 2214 Cedley St. Balto Md.

Length of stay in Baltimore 9yr. (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F	W.	S	Dec 4, 1939	9 10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Garden City Long I. N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.

FATHER'S NAME Donald C Ross
14. MOTHER'S MAIDEN NAME Vera Elizabeth Schmidt.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Dr. Father ADDRESS

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bulbar Poliomyelitis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bilateral Bronchopneumonia

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-4 *, 1949, to* 9-4 *, 1949, that I last saw the deceased alive on* 9-4 *, 1949, and that death occurred at* 4^10 p *m., from the causes and on the date stated above.*

23A. SIGNATURE Garrett E Deane M. D.
23B. ADDRESS Univ. Hosp, Balto Md.
23C. DATE SIGNED 9-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9/8/49
24C. NAME OF CEMETERY OR CREMATORY London Park
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1217 St. Paul St.

VS 150

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386 ✓ 581.0 077856

JL- 131017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Charles Frosburg

2. DATE OF DEATH 92- 49(9-2-49)

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1929 E. Pratt St. 2-01

Length of stay in Baltimore Life Yrs. Mon. Days

SEX M | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Sep.

8. DATE OF BIRTH July 17,1910 | 9. AGE (In years last birthday) 39 yrs. | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles (D)

14. MOTHER'S MAIDEN NAME Stella Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT B. C. H. Records, 4940 Eastern Ave. ADDRESS

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis Of The Liver

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-13-49, 19__, *to* Sept. 2, 1949, *that I last saw the deceased alive on* Sept. 2, 1949, *and that death occurred at* 12.20 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE L. L. Royer M. D. | 23B. ADDRESS 4940 Eastern Ave. | 23C. DATE SIGNED 9- 3- 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Sept 6/49 | 24C. NAME OF CEMETERY OR CREMATORY Balto Cem | 24D. LOCATION (City, town, or county) Balto (State)

DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Ulman Funeral Home ADDRESS 2008 Orleans St

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 yr

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Elmore, Mary V.

2. DATE OF DEATH Sept. 2, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Doctors Hospital

Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Lake Shore Pasadena
D. STREET ADDRESS (If rural, give location) 9 Luke Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	MAR 22-1888	61	5	11

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Virginia	

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Bertha Mae Elmore	9 Luke Drive Lake Shore Pas.

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial infarction — Interval between onset and death: none

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Congestive Heart failure — one month

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept. 1, 1949, *to* Sept. 2, 1949, *that I last saw the deceased alive on* Sept. 2, 1949, *and that death occurred at* 5:18 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis Glanville M. D.	Doctor's Hospital	Sept. 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 6, 1949	Louden Park Cem.	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 6-1949	Hunter Williams, M.D.	Joseph F. Ambrose	1329 Lafayette Spring Rd

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

151

TH NO. — Registered No.

NAME OF DECEASED (Type or Print) Elizabeth Ziegler

2. DATE OF DEATH: September 4, 49

PLACE OF DEATH: Baltimore City, Maryland 3601 Harlem Ave.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 3601 Harlem Ave. 6-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F M	White	Widowed	Aug. 22, 1879	79		

9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home	Home	Maryland	USA

13. FATHER'S NAME: Henry Hagedorn

14. MOTHER'S MAIDEN NAME: Caroline Woolford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	NO	Harry Ziegler	2700 Harlem Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 10 Mos.

DUE TO

(B)

DUE TO

(C) Hypertrophic arthritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov. 8 1948, *to* Sept. 7, 1949, *that I last saw the deceased alive on* Sept 7, 1949, *and that death occurred at* 10 35 ~~P~~ A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Paul R. Ziegler M. D.	3723 Edmondson ave	9/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 7, 49	Lorraine	Woodlawn Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
9-6-1949	Huntington Williams, M.D.	J.T. Stansbury	2700 Edmondson Ave.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48

Registered No. 077889

TH NO.

NAME OF DECEASED (Type or Print) LOUISE IRENE MEYER

2. DATE OF DEATH Sept. 3, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2909 Dillon Street

Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2909 Dillon Street 1-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
F	W	Married

8. DATE OF BIRTH: Aug. 24, 1899
9. AGE (In years last birthday): 50 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Amandus Anderson
14. MOTHER'S MAIDEN NAME: Lizetta Rau

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none

17. INFORMANT 2909 Dillon Street -24
Mr. Nicholas H. Meyer

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF THROAT. — INTERVAL BETWEEN ONSET AND DEATH: 1 YR.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PERNICIOUS ANEMIA — 1 1/2 Yrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* FEB, 1948 *to* SEPT 3, 1949, *that I last saw the deceased alive on* SEPT 3, 1949, *and that death occurred at* 12-15 p m., *from the causes and on the date stated above.*

23A. SIGNATURE James F Cavanagh MD M. D.
23B. ADDRESS 3014 W Cedary St
23C. DATE SIGNED 9-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9/6/49
24C. NAME OF CEMETERY OR CREMATORY Meadow Ridge Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.

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BALTIMORE - 13, MARYLAND 45F

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

STATE NO. 163 Registered No.

NAME OF DECEASED (Type or Print): WALTER FORD

2. DATE OF DEATH: 9/3/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pasadena R.D.
D. STREET ADDRESS (If rural, give location): Magothy Beach

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	May 5 1920	29		

9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10a. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shop Filler		Md.	

13. FATHER'S NAME: Eugene Ford

14. MOTHER'S MAIDEN NAME: Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Specify yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		212-10-7602	Sister	Same

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Infarct — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Phlebothrombosis Left Leg. — DUE TO

(C) Osteomyelitis of L. Femur

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/1 19[illegible] *to* 9/3, 19[illegible] *that I last saw the deceased alive on* 9/3, 19[illegible] *and that death occurred at* [illegible] *p.* m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Nicholas Malley M. D.	Univ Hosp.	9/3/49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, Town, or County) (State)
Burial	9/7/49	Wesley Chapel	Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 6 - 1949	Huntington Williams, MD	Edward Toulson	2379 Wash Blvd

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

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TH NO.

Registered No.

NAME OF DECEASED (Type or Print) Helen Russell

2. DATE OF DEATH September 4 1949

PLACE OF DEATH: Baltimore City, Maryland N. Broadway

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Baltimore
If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 4129 Roland Ave. 13-07

Length of stay in Baltimore — 70 Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Single	7-8-78	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Md.	

13. FATHER'S NAME Alexander Russell

14. MOTHER'S MAIDEN NAME Sarah Keech

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	No	None

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
DUE TO ureteral stricture, left
Surgical absence of kidney, right — 11 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Papillomata of bladder

(C) Hypertension

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-9, 1949 *to* 9-4, 1949, *that I last saw the deceased alive on* 9-4, 1949, *and that death occurred at* 5 30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lawrence R. Wharton M. D.	JOHNS HOPKINS HOSPITAL	9-4-49

24A. BURIAL, CREMATION OR REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept-7/49	Green Mount	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
		Stewart Memorial	Balto.

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7892 — BALTIMORE CITY HEALTH DEPARTMENT — 331 — Registered No. 077892

TH NO.

CERTIFICATE OF DEATH

NAME OF DECEASED (Type or Print): Minnie Nickel

2. DATE OF DEATH: 9-2-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctors Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1423 Moorden Way (24)
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 26-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	White	Married	June 20, 1903	46	2	12	22	45

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Braunschweiger
14. MOTHER'S MAIDEN NAME: Rose Pachoeffin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Earl Nickel — ADDRESS: 1423 Moorden Way

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Cerebral Hemorrhage
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-2-, 1949, *to* 9-2, 1949, *that I last saw the deceased alive on* 9-2, 1949, *and that death occurred at* 1045 Pm *from the causes and on the date stated above.*

23A. SIGNATURE: Louis J. Sloan M. D.
23B. ADDRESS: 2730 N Charles St
23C. DATE SIGNED: 9-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 7 1949
24C. NAME OF CEMETERY OR CREMATORY: Morelands
24D. LOCATION (City, town, or county) (State): Taylor Ave

DATE RECEIVED BY LOCAL REGISTRAR: 9/6/49
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leo D. Leach — ADDRESS: 1703 N Patterson Park Av

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7893 — BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

TH NO. 7893 — Registered No. 077893

NAME OF DECEASED (Type or Print): MARY TERESA RYAN

2. DATE OF DEATH: SEPT. 5, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HOSPITAL FOR WOMEN OF MD.

Length of stay in Baltimore: ~~Yrs.~~ ~~Mos.~~ 2 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTIMORE 27-34
D. STREET ADDRESS (If rural, give location): 4405 GLENMORE AVE.

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: SEPT. 3 1949
9. AGE (In years last birthday): If Under 1 Year: Months 0 Days 2; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: HARRY MICHAEL RYAN
14. MOTHER'S MAIDEN NAME: ANNA MARIE WAGNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 0
17. INFORMANT: HOSPITAL RECORDS — ADDRESS:

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE

DUE TO

ANTECEDENT CAUSES

(B) DIFFICULT BREECH EXTRACTION

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) INCOMPLETELY DILATED CERVIX

INTERVAL BETWEEN ONSET AND DEATH: 2 DA.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 9-3-49
19B. MAJOR FINDINGS OF OPERATION: DOUBLE FOOTLING BREECH EXTRACTION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* SEPT. 3, 1949, *to* SEPT. 5, 1949, *that I last saw the deceased alive on* SEPT. 5, 1949, *and that death occurred at* 4:25 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE: James D. McCook, M. D.
23B. ADDRESS: 1014 St. Paul St. - Baltimore
23C. DATE SIGNED: 9/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-6-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Leonard J. Leach
ADDRESS: 5305 Harford

VS 150

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894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 977894

TH NO.

NAME OF DECEASED (Type or Print): Jennie E. Breithaupt

2. DATE OF DEATH: 9-4-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): John Hopkins Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-01
D. STREET ADDRESS (If rural, give location): 313 Herring Court

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	widow	Oct. 15, 1873	75 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Salisbury, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Zeddie Gordy
14. MOTHER'S MAIDEN NAME: - Jackson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. Zeddie Breithaupt ADDRESS: Pikesville, Md.

CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

(B) Arteriosclerosis Generalized

DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Robert L. McFadden M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 9/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/7/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS | ADDRESS: Balto., Md.

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7895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

34

0777895

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): MARY VIRGINIA BOWINKELMAN

2. DATE OF DEATH: Sept. 4, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 322 S. Eutaw St.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 322 S. Eutaw St. 22-02

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	white	married	Aug. 16, 1879	70 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Hyson
14. MOTHER'S MAIDEN NAME: Mary Harvey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mr. LeRoy Bowinkelman
ADDRESS: 415 S. Paca St.

CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Right Cerebral Hemiplegia — 3 days

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-1, 1949, *to* 9-3, 1949, *that I last saw the deceased alive on* 9-2, 1949, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edmund Heven, M. D.
23B. ADDRESS: 3400 Hilton Rd
23C. DATE SIGNED: 9/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/7/49
24C. NAME OF CEMETERY OR CREMATORY: Balto. Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

837

7896 — BALTIMORE CITY HEALTH DEPARTMENT — 0777896

CERTIFICATE OF DEATH

153

TH NO. — Registered No.

NAME OF DECEASED (Type or Print): SAMUEL JOSEPH SPROW Sr. — 2. DATE OF DEATH: 9/4/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3603 Cedardale Rd.

Length of stay in Baltimore: 67 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE Md.
D. STREET ADDRESS (If rural, give location): 3603 Cedardale Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	Mar. 14 1882	67		

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Building Contractor	Self employed	Balto Md.	U.S.A.

13. FATHER'S NAME: Samuel D. Sprow
14. MOTHER'S MAIDEN NAME: Kate Tierney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		none	Son	7301 York Road.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs 7 mo.

DUE TO

(B) Primary Carcinoma, sigmoid

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Feb 1949	Carcinoma sigmoid Colon & Obstruction	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9/4, 19__, *to* 9/4, 1949, *that I last saw the deceased alive on* 9/4, 1949, *and that death occurred at* 1 00 m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Harry M Beck M. D.	300 N. Charles St.	9/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/8/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR. ADDRESS
		WM. J. TICKNER & SONS Balto., Md.

VS 150

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7897

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

RTH NO. | Registered No. 7897

NAME OF DECEASED (Type or Print): ANNA B. KRAUSE

2. DATE OF DEATH: Sept. 4, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 349 S. Cornwall Street 26-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	5/14/1897	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Maryland	U.S.A.

13. FATHER'S NAME: Henry Miller

14. MOTHER'S MAIDEN NAME: Rosa Curtiss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	None	?

17. INFORMANT: Henry Krause (husband) ADDRESS: 349 S. Cornwall St.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* AUTOPSY (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said ~~Autopsy~~ Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: H. G. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/8/49	Oak Lawn	Baltimore - Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 6 1949 — [illegible] M.D.

25. FUNERAL DIRECTOR: Lilly & Zeibert — ADDRESS: 403 E. Wolfe St

VS 151

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77898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H.O

077898

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Catherine Loyall

2. DATE OF DEATH: SEP 4 - 1949

PLACE OF DEATH: Baltimore City, Maryland Osler 4

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1 or
D. STREET ADDRESS (If rural, give location): 2803 Eastern Ave.

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year: Months / Days / Hours / Min.)
Female	White	married	9/5/1897	51

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: ?

11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Humphreys

14. MOTHER'S MAIDEN NAME: Cinnie Gouss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): No —

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Occlusion Superior mesenteric artery & gangrene of bowel — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Embolus from left auricle
DUE TO
(C) Mitral Stenosis due to Rheumatic fever

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-4-, 1949 *to* 9-4-, 1949 *that I last saw the deceased alive on* 9-4-, 1949 *and that death occurred at* 6 50 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Ralph H. Schoenfeld M.D. | 23B. ADDRESS: JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED: 9/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 9/5/49 | 24C. NAME OF CEMETERY OR CREMATORY: London Park | 24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE: Evangeline Williams M.D | 25. FUNERAL DIRECTOR ADDRESS: Lilly & Zeiler Inc. 403 S Wolfe St

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92B

CERTIFICATE CORRECTED 10-6-49

0777899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1 0777899

TH NO. Registered No.

NAME OF DECEASED (Type or Print) ALVIN PHILLIPS ADAMS

2. DATE OF DEATH 5th Sept 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 302 TUNBRIDGE RD.

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO.
D. STREET ADDRESS (If rural, give location) 302 TUNBRIDGE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	MARRIED	OCT. 13, 1875	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ARSON ADAMS
14. MOTHER'S MAIDEN NAME: ANNIE L. FISHER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: CARRAINGE ADAMS ADDRESS: SAME

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CORONARY THROMBOSIS.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: immediate

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5th Sept 1949, to 5th Sept 1949, that I last saw the deceased alive on 5th Sept 1949, and that death occurred at 2 or P m., from the causes and on the date stated above.

23A. SIGNATURE: W Bernard Valle M. D.
23B. ADDRESS: 5 W Cathedral St. 5
23C. DATE SIGNED: 5th Sept 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: SEPT. 7, '49
24C. NAME OF CEMETERY OR CREMATORY: LOUDON PARK
24D. LOCATION (City, town, or county) (State): BALTO., MD.

DATE RECEIVED BY LOCAL REGISTRAR: 9-6-49
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: H. W. JENKINS & SONS CO. ADDRESS: 4905 YORK RD.

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077900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

077900 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) MARY BEACH (Mary E. Beach)

2. DATE OF DEATH 9/5/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General

Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-09
D. STREET ADDRESS (If rural, give location) 1224 E Federal St

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	Widowed	2/3/88	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hugh Eagan
14. MOTHER'S MAIDEN NAME Caroline Frederick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No, no or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular Hemorrhage
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/2, 1949 *to* 9/5, 1949, *that I last saw the deceased alive on* 9/5, 1949 *and that death occurred at* 2 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Charles J. Blazek, M. D.
23B. ADDRESS Maryland General
23C. DATE SIGNED 9/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify) 24B. DATE 9-8-49
24C. NAME OF CEMETERY OR CREMATORY Morelands Memorial Park
24D. LOCATION (City, town, or county) (State) Taylor Ave, Balto: Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 6 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS George J. Ruth, Inc. - 1735 Harford Avenue

VS 150

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077961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

077961

TH NO. Prov. 1 Registered No.

NAME OF DECEASED (Type or Print)
PAUL SAVITCH SOROKA

2. DATE OF DEATH 4 Sept. 1949

PLACE OF DEATH: Baltimore City, Maryland Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
8 S. Collington Ave.

Length of stay in Baltimore 36 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 8 S. Collington Ave. 1-05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	23 Dec., 1882	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): Hulevtzi (1st. Papers)
12. CITIZEN OF WHAT COUNTRY? Russia
13. FATHER'S NAME: Sam Soroka
14. MOTHER'S MAIDEN NAME: Paraska Deduk
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 212-16-9717
17. INFORMANT: Mrs. Martha Soroka, ADDRESS: 8S. Collington

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 15 mins.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* 4 Sept., 1949, *and that death occurred at* 1:50 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Theodore Kardash
Theodore Kardash, MD M. D.
23B. ADDRESS: Medical Arts Bldg
23C. DATE SIGNED: 9-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 7 Sept. 1949
24C. NAME OF CEMETERY OR CREMATORY: St. Andrews Russian
24D. LOCATION (City, town, or county) (State): German Hill Rd. Balto.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Walter Brooks Bradley
ADDRESS: Walter Brooks Bradley, Dundalk, Md.

VS 150

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(77902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1949

(77902 Registered No.

TH NO.

1. NAME OF DECEASED (Type or Print) MILDRED MADISON

2. DATE OF DEATH 9-4-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) PROVIDENT HOSPITAL

Length of stay in Baltimore 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 12 03
D. STREET ADDRESS (If rural, give location) 1526 CLIFTON AVENUE

5. SEX F | 6. COLOR OR RACE NEGRO | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 9/15/00 | 9. AGE (In years last birthday) 48 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) VIRGINIA | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BEVERLY JETER | 14. MOTHER'S MAIDEN NAME HAWES BROWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO | 16. SOCIAL SECURITY NO | 17. INFORMANT CLARENCE MADISON | ADDRESS 1526 CLIFTON AVE Balto

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	HYPOSTATIC PNEUMONIA	7 DAYS
DUE TO (B)	GENERALIZED CARCINOMATOSIS	UNDET.
DUE TO (C)	CARCINOMA OF CERVIX UTERI	UNDET.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. SEVERE SECONDARY ANEMIA | UNDET.

19A. DATE OF OPERATION NONE | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 26, 1949 to Sept. 4, 1949, that I last saw the deceased alive on Sept 4, 1949, and that death occurred at 0115 m., from the causes and on the date stated above.

23A. SIGNATURE Clarence Clarke M. D. | 23B. ADDRESS Provident Hospital | 23C. DATE SIGNED 9/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Sept. 7 1949 | 24C. NAME OF CEMETERY OR CREMATORY Family lot | 24D. LOCATION (City, town, or county) Royce, Va (State)

DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR Holland Funeral Home | ADDRESS 1631 Dinwiddie Hill Ave.

VS 150

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Med. Exam. Case
077903
Released to Hoop.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 437.3

077903 Registered No.

STH NO.

NAME OF DECEASED (Type or Print): Ora Curry. 145-437

2. DATE OF DEATH: SEP 5 - 1949

PLACE OF DEATH: Baltimore City, Maryland 'Osler 6

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26 06
D. STREET ADDRESS (If rural, give location): 5804 Osprey LANE

Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
Female	colored	Married ?	Sept. 18, 1898	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife ?
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): W. Keesport, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lee Wallace ?
14. MOTHER'S MAIDEN NAME: Delia Arnold ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonary edema

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardiac hypertrophy

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
Robert B. McFadden, M.D.
per W. J. McClafferty M.D.
CHIEF OR ASST. MEDICAL EXAMINER

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-5-, 1949 *to* 9-5-, 1949, *that I last saw the deceased alive on* 9-5-, 19 49 *and that death occurred at* 9:10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Walter Arons M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 8, 1949	Arbutus Mem. Pk.	Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 150
To be approv. by Child's Exam.
95C

7904 — BALTIMORE CITY HEALTH DEPARTMENT — G77904

CERTIFICATE OF DEATH

322 Registered No.

RTH NO.

NAME OF DECEASED (Type or Print): MAE J. PARLETT

2. DATE OF DEATH: September 4, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township) 3-01
D. STREET ADDRESS (If rural, give location): 267 Herring Court

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Married	June 7, 1911	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not known
14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Benjamin Parlett — ADDRESS: Box 30, Middle River, Md

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic alcoholism
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 9-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 7, 1949	Baltimore	North Avenue & Rose Street

DATE RECEIVED BY LOCAL REGISTRAR: 9/6/49
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Clarence F. Hoffman — ADDRESS: 1639 Broadway

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905 — 446 — 077905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

STH NO.

NAME OF DECEASED (Type or Print): Isaac Fisher

2. DATE OF DEATH: 9-2-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp.

Length of stay in Baltimore: LIFE. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1038 WILMER. CT.

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Colored	MARRIED	2-11-08	41		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AUTO. MECH.
10a. KIND OF BUSINESS OR INDUSTRY: GARAGE
11. BIRTHPLACE (State or foreign country): BALTO. Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: WILLIAM FISHER
14. MOTHER'S MAIDEN NAME: RUTH CRAIG
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 218-18-4155
17. INFORMANT: RACHAEL FISHER. ADDRESS: SAME

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Nephrosclerosis
DUE TO
(C) Essential hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-25 *1949, to* 9-2, *1949 that I last saw the deceased alive on* 9-2, *1949, and that death occurred at* 12:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Lucius W. Luper M. D.
23B. ADDRESS: Provident Hosp.
23C. DATE SIGNED: 9-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/6/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 6 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo. H. Nelson
ADDRESS: 1303 Braddish Av

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

Registered No. 977906

TH NO.

NAME OF DECEASED (Type or Print) Edward Robinson

2. DATE OF DEATH September 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR STITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-04
D. STREET ADDRESS (If rural, give location) 1732 W. North ave.

Length of stay in Baltimore 35 Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	Colored	Married	4-7-06	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Porter		Md.	

13. FATHER'S NAME John Robinson

14. MOTHER'S MAIDEN NAME Laura Ferguson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
				JOHNS HOPKINS HOSPITAL

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardio-vascular disease

DUE TO

(B) Uremia and cardiac failure

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-21, 1949, *to* 9-1, 1949, *that I last saw the deceased alive on* 9-1, 1949, *and that death occurred at* 8 20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Edythe H. Schoenrich M. D.	JOHNS HOPKINS HOSPITAL	9/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/6/49	Mt Calvary	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 6 1949	Huntington Williams, M.D.	Geo. L. Kelson	303 Breesteman

VS 150

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077907 BALTIMORE CITY HEALTH DEPARTMENT 077907

CERTIFICATE OF DEATH

43 Registered No.

RTH NO.

NAME OF DECEASED (Type or Print) ELLAE JOHANSEN

2. DATE OF DEATH 9-4-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Agnes Hospital

Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-C

D. STREET ADDRESS (If rural, give location) 447 Brunswick St.

3. SEX	5. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE In years last birthday	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
F	W.	W	9-27-1883	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md.	U.S.A.

13. FATHER'S NAME Arthur Meyer

14. MOTHER'S MAIDEN NAME L. Meyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT William P. Johansen ADDRESS

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Arteriosclerotic Hypertensive CVD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/2 1949, to 9/4 1949 *that I last saw the deceased alive on* 9/4, 1949, *and that death occurred at* 1:40 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE Robert J. Kerickas M. D. | 23B. ADDRESS St. Agnes Hospital | 23C. DATE SIGNED 9/4/49 (Date)

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE SEPT. 7 '49 | 24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR SEP 6-1949 | REGISTRAR'S SIGNATURE Remington Williams M.D.

25. FUNERAL DIRECTOR Nancy A. Hatzfeld ADDRESS 4101 Edmondson Ave

937

077908

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

077908

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) **JANIE KADY**

2. DATE OF DEATH **9-3-49**

PLACE OF DEATH: D. O. A. **PROVIDENT - Hospt**
Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Provident Hospt. 1500 Blk. Druid Park Dr.**

Length of stay in Baltimore: Yrs. **Life** Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **715 W. Lafayette Ave.** 17-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
F.	C.	Single	7-25-1924	25		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Sub-Montgomery Wards Dept. Store**
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Balto. Md.**
12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Haywood Cady**
14. MOTHER'S MAIDEN NAME **Carrie Lawton**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT **Haywood Cady** ADDRESS **715 W Lafayette Ave**

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Pernicious anemia** — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **May 13**, 19**46** *to* **Aug. 15**, 19**49**, *that I last saw the deceased alive on* **Aug. 15**, 19**49**, *and that death occurred at* **9:30a** m., *from the causes and on the date stated above.*

23A. SIGNATURE **C. Campbell** M. D. | 23B. ADDRESS **718 Dolphin St.** | 23C. DATE SIGNED **9-3-49**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** | 24B. DATE **9-7-49** | 24C. NAME OF CEMETERY OR CREMATORY **Mt. Calvary Cemetery** | 24D. LOCATION (City, town, or county) (State) **Cedar Hill Md.**

DATE RECEIVED BY LOCAL REGISTRAR: SEP 6 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: **William A. Carlson** | ADDRESS: **916 Penna Ave.**

73a

077909

CERTIFICATE CORRECTED 11-23-49 ✓ Medical Examiners Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 977 077909

Registered No.

TH NO. N-863

NAME OF DECEASED (Type or Print) IDA LEVINSON

2. DATE OF DEATH SEPT. 5, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore, Inc.

Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3-03
D. STREET ADDRESS (If rural, give location) 118 No Patterson Park Ave

5. SEX male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Oct. 29, 1891 | 9. AGE (In years last birthday) 57 65 38 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia | 12. CITIZEN OF WHAT COUNTRY? CERTIFICATION APPROVED BY FOR J. R. DAVIS, M.D. CHIEF DEPUTY MEDICAL EXAMINER

13. FATHER'S NAME Abraham

14. MOTHER'S MAIDEN NAME Eudyze

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Joseph Levinson 118 No Paterson Pk

18. CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemoperitoneum, peritonitis secondary — 9 Days

DUE TO

(B) Traumatic laceration of abdomen;

DUE TO

(C) Complete transection of transverse colon & ileum; laceration of mesocolon & mesentery of small bowel.

DUE TO

(D) ASCVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION Aug. 27, 1949 | 19B. MAJOR FINDINGS OF OPERATION Traumatic laceration of abdomen; complete transection transverse mesocolon & ileum; laceration of mesocolon | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Suicide | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 118 h. Patterson Park Ave.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 27, 1949 m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? Self inflicted Sharp Instrument

22. I hereby certify that I attended the deceased from Aug. 27, 1949 to Sept. 5, 1949, that I last saw the deceased alive on Sept. 5, 1949, and that death occurred at 11:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE Nathan L. Laeon M. D. | 23B. ADDRESS Sinai Hospital | 23C. DATE SIGNED Sept. 6/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-6-49 | 24C. NAME OF CEMETERY OR CREMATORY Hebrew Herring Run | 24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 6- | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Jack Lewis Inc | ADDRESS 2100 Eastern Ave

VS 150

1649

G77910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G77910

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARD SYKES

2. DATE OF DEATH: September 2, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

Length of stay in Baltimore: 20 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1524 N. Broadway

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 8- 92
9. AGE (In years last birthday): 56
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10B. KIND OF BUSINESS OR INDUSTRY: Balto. City
11. BIRTHPLACE (State or foreign country): Elizabeth city N. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Sedas Sykes
14. MOTHER'S MAIDEN NAME: Mary Jane Bennett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:

17. INFORMANT: Clara Sykes ADDRESS: 1524 N. Broadway

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractures of ribs, pelvis, and left femur.
DUE TO
(B) Perforation of intestine.
DUE TO
(C) Terminal bronchopneumonia.

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Golf Course
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Hilsdale Golf Course, Green at Hilsdale Road & Forest Park Ave.,
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Sept. 1, 1949 10:45 A m.
21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? Tractor overturned

28/2

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 9-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 6-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP - 1949 / SEP 6 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1011 Beaty Ave

176

G77911 ✓ G77911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

RTH NO. Registered No.

NAME OF DECEASED (Type or Print) JAMES P. SUMMERVILLE (SUMMIELL)

2. DATE OF DEATH Sept. 5, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

Length of stay in Baltimore 18 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 612 North Caroline Street 5-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	married	March 20-80	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stock Clerk	Art. Sup. Co	St Marys Co Md	U.S. A.

13. FATHER'S NAME Henry Summerville

14. MOTHER'S MAIDEN NAME Ruth Tier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, or unknown, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Saddie Summerville	612 N

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		INTERVAL BETWEEN ONSET AND DEATH
I	(A) Arteriosclerotic cardiovascular		Approx. 1 wk.
	DUE TO disease		
	ANTECEDENT CAUSES		
	(B)		
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
II	(C)		
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
Russell S Fisher M.D.		Sept. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 8, 49	Mt Calvary Cem	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 6-1949	Thurlington Williams, M.D.	Elroy O. Wilson	1005 Bridge 93D

VS 151

077912

077912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

STH NO.

1. NAME OF DECEASED (Type or Print): Charles Hughes 215819

2. DATE OF DEATH: SEP 3 - 1949

3. PLACE OF DEATH: Baltimore City, Maryland — Halsted - 2

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 414 N. ANN St. 6 65

Length of stay in Baltimore: 53 years (Yrs. / Mos. / Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	Colored	Single	10-25-95	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Hughes

14. MOTHER'S MAIDEN NAME: Ella - ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes (If yes, give war or dates of service): WAR I

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS:

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Intestinal obstruction; Uremia.	36 hrs.
DUE TO (B)	Incarcerated inguinal hernia, rt.	48 hrs.
DUE TO (C)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Epidural anesthesia — 20 min.

19A. DATE OF OPERATION: 9-1-49

19B. MAJOR FINDINGS OF OPERATION: Rt. inguinal hernia; small bowel incarceration

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 9-1- 1949 *to* 9-3 1949, *that I last saw the deceased alive on* 9-3 1949, *and that death occurred at* 12 06 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Owen C. McKean, M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 9-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Sept 7-49

24C. NAME OF CEMETERY OR CREMATORY: Bolly Mt. Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 6 - 1949

REGISTRAR'S SIGNATURE:

25. FUNERAL DIRECTOR: Chas D. Wilson — ADDRESS: 1710 Brantly Balto

HS 150

122a

AB-128684 (47913)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16 (47913) Registered No.

RTH NO.

NAME OF DECEASED (Type or Print): George Milke

2. DATE OF DEATH: Sept. 4-1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 107 N. Bradford St. 6-03

5. SEX: M
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 6-1906
9. AGE (In years last birthday): 43 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Milke

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Baltimore City Hospitals ADDRESS Records: 4940 Eastern Ave.

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchogenic Carcinoma left upper lobe — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Generalized Carcinomatosis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-2 *to* 9-4-49 *that I last saw the deceased alive on* 9-4-49 *and that death occurred at* 8.20 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 9-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 9-8-49
24C. NAME OF CEMETERY OR CREMATORY: Schwartz Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John F. Connelly
ADDRESS: 418 Eastern Ave Balto 21 Md

47c

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C.M.-104366

077914

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

077914

BIRTH NO.

Registered No.

NAME OF DECEASED (Type or Print): Eva Lee

2. DATE OF DEATH: Sept. 3, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN: Baltimore
(If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 552 Baker St. 14-03

Length of stay in Baltimore: 4 years (Yrs. Mon. Days)

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: March 24, 1899
9. AGE (In years last birthday): 50 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Morris Lee
14. MOTHER'S MAIDEN NAME: Betty Lee
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: B.C.H. Records ADDRESS: 4940 Eastern Ave.

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Due to Hypertensive Arterio Sclerotic

DUE TO Cardio Vascular Disease.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-7, 1946, *to* 9-3, 1949, *that I last saw the deceased alive on* 9-3, 1949, *and that death occurred at* 5.25 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: J. L. Rogers M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 9-3-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-8-1949
24C. NAME OF CEMETERY OR CREMATORY: Mount Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore City Maryland

DATE RECEIVED BY LOCAL REGISTRAR: SEP 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Joseph A. Sisly 661 W. Base Street

VS 150

61

077915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 910.3 077915

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Erland Nordling

N-863.0

2. DATE OF DEATH: Sept. 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Turner Station
D. STREET ADDRESS (If rural, give location): 7 Cottage Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
M	W	Single	Not know	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Boat Yard	Finnish	

13. FATHER'S NAME: ? Nordling

14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-10-2842

17. INFORMANT: Unger + Mahon, Inc. ADDRESS: P.O. Box #011 Brooklyn Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute peritonitis, due to

DUE TO (B) Rupture of intestine.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): company

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Unger and Mahon at Turners Station

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Aug. 30, 1949 2 P m.

21E. INJURY OCCURRED: WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR? struck by piece of lumbar

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR [X]

23C. DATE SIGNED: Sept. 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept-6-49	Holy Trinity Russian	Elkridge Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 6-1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: J. A. Grekiewicz Jr. ADDRESS: 1905 E. Fritz

195E

VS 151

CERTIFICATE CORRECTED 11-3-49 ✓

G77916 — G77916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Lewis E. Odette

2. DATE OF DEATH: 9/2/49

PLACE OF DEATH: Baltimore City, Maryland — Balto. Md

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6000 Highgate Drive

Length of stay in Baltimore: 10 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-22
D. STREET ADDRESS (If rural, give location): 6000 Highgate Drive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M.	W.	Widower	1/17/83	65		

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Westinghouse
11. BIRTHPLACE (State or foreign country): Vermont
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Odette
14. MOTHER'S MAIDEN NAME: Sarah Lawrence

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): (yes, no or unknown)
16. SOCIAL SECURITY NO.: 015-03-7216
17. INFORMANT: Rahlman E. Odette ADDRESS: 615 Washington Rd

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure; asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-vascular Disease ?
DUE TO →
(B) ? Coronary Thrombosis 2 wks
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1947 *to* Sept. 2, 1949 *that I last saw the deceased alive on* Sept 2, 19 49 *and that death occurred at* 1105 A m. *from the causes and on the date stated above.*

23A. SIGNATURE: A. A. Sampson M. D.
23B. ADDRESS: 1109 N. Calvert St
23C. DATE SIGNED: 9-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): cremation
24B. DATE: 9/7/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Pk. Crematory
24D. LOCATION (City, town, or county) (State): 3801 Frederick Rd. Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 6 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry N. Lutz & ADDRESS: 4101 Edmondson Ave

VS 150

931

077917

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No. 077917

TH NO.

NAME OF DECEASED (Type or Print): Pearl M. Palmerino

2. DATE OF DEATH: Sept. 4/49

PLACE OF DEATH: Baltimore City, Maryland. Balto. Md.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 404 E. Chase St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 404 E. Chase St.

Length of stay in Baltimore: Life Yrs. 10 Mos. 01 Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	W.	Widow	Aug. 29, 1904	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Lady
10B. KIND OF BUSINESS OR INDUSTRY: Pitts Canning
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Walter Harrison
14. MOTHER'S MAIDEN NAME: Cora Grimes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Chas. M. Palmerino ADDRESS: 1103 Webb Court

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mons

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb 1, 1949, *to* Sept. 4, 1949, *that I last saw the deceased alive on* 9/4, 1949, *and that death occurred at* 4 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hargaman Willis M. D.	2030 Wilkens Ave	9/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 7/49	Loudon Pk.	3801 Frederick Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
9-6-19	[illegible] Williams, M.D.	Harry H. Swift &	4101 Edmondson Ave

VS 150

937

077918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 Registered No. 156620

077918

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEOPOLD H. MAHRENHOLZ

2. DATE OF DEATH 9-5-1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2526 W. Pratt street 20-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	9-18-1872	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Ludwig

14. MOTHER'S MAIDEN NAME Minnie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Celia Mahrenholz ADDRESS 2526 W. Pratt St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Stomach with Metastases to Liver
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis, Generalized

INTERVAL BETWEEN ONSET AND DEATH: (A) ?

19A. DATE OF OPERATION 8/31/49

19B. MAJOR FINDINGS OF OPERATION Carcinoma of Stomach with Metastases to Liver

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/29, 1949 *to* 9/5, 1949, *that I last saw the deceased alive on* 9/4, 1949, *and that death occurred at* 2:50 A m., *from the causes and on the date stated above.*

23A. SIGNATURE R. V. Ramsey M. D.

23B. ADDRESS St. Agnes Hospital

23C. DATE SIGNED 9/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9/8/49

24C. NAME OF CEMETERY OR CREMATORY New Cathedral

24D. LOCATION (City, town, or county) (State) 4300 Old Frederick Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE Catherine Williams, M.D.

25. FUNERAL DIRECTOR Harry A. Wittstadt ADDRESS 4101 Edmondson Ave

SEP 6 1949

46.B

MEDICAL CERTIFICATION

077919

077919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Caroline Wilhelmina Schlendorf

2. DATE OF DEATH: 9/4/49

PLACE OF DEATH: Baltimore City, Marylan Baltimore, Md.

FULL NAME OF SPITAL OR STITUTION (If not in hospital or institution, give street address or location): 600 Lyndhurst St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 29
D. STREET ADDRESS (If rural, give location): 600 Lyndhurst St. 16-08

Length of stay in Baltimore: 32 yrs. (Yrs. Mos. Days)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	W.	Widow	July 10, 1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ousewife	Own home	Germany	U.S.A.

13. FATHER'S NAME: orge Hesterberg

14. MOTHER'S MAIDEN NAME: Sophie-----

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: daughter — ADDRESS: Mrs. Minna Linthicum, 600 Lyndhurst

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24hr.

DUE TO

(B) Congestive Heart Failure — 16 da.

DUE TO

(C) Hypertensive Cardio-Vascular Disease — 20 yr(?)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-29, 1945 *to* 9-4, 1949 *that I last saw the deceased alive on* 9-4, 1949 *and that death occurred at* 1055 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Melvin K. Talbert M. D.	6209 Frederick Rd. Balto. 28	9-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/8/49	Loudon Park, 3801 Frederick Rd. Balto. 29, Md.	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 6-1949	Huntington Williams, M.D.	Harry A. Reitzel	4101 Edmondson Ave

VS 150

93D

077920 CERTIFICATE CORRECTED 9-15-49 ✓

BALTIMORE CITY ~~HEALTH DEPARTMENT~~

CERTIFICATE OF DEATH

STATE FILE NO. 077920 Registered No.

1. NAME OF DECEASED (Type or Print) ROTH, Frederick William

2. DATE OF DEATH Sept 6 1949.

3. PLACE OF DEATH: Baltimore City, Maryland Union Memorial Hosp.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TOWSON.
D. STREET ADDRESS (If rural, give location) 101 YORK ROAD

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W.	M.	Mar 20-1900	49	5 / 16	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Palmist

10b. KIND OF BUSINESS OR INDUSTRY self

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Roth

14. MOTHER'S MAIDEN NAME Margaret

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Lily Sparrow ADDRESS 912 N. Ft. N.E. Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

DUE TO

(B) ARTERIOSCLEROTIC HEART DISEASE — 1 yrs

DUE TO

(C) NONE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

NONE

19A. DATE OF OPERATION NONE

19B. MAJOR FINDINGS OF OPERATION NONE

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) NONE

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) NONE

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) NONE m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ NONE

21F. HOW DID INJURY OCCUR? NONE

22. I hereby certify that I attended the deceased from Sept. 1944 to Sept. 6 1949, that I last saw the deceased alive on Sept 6 1949, and that death occurred at 1:40 A m., from the causes and on the date stated above.

23A. SIGNATURE A. S. Chaffant M.D.

23B. ADDRESS 6210 YORK ROAD

23C. DATE SIGNED Sept 6 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE 9/8/49

24C. NAME OF CEMETERY OR CREMATORY Ft. Lincoln CEMETERY

24D. LOCATION (City, town, or county) (State) WASHINGTON, D.C. Prince George County, Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 6-1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR W. W. Chambers Co

ADDRESS 517 11th St S.E.

VS 150

93D

✓X 1 077921

077921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Marion Forsythe

2. DATE OF DEATH September 5, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) PINECREST SANATARIUM

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY MONTGOMERY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TACOMA PARK
D. STREET ADDRESS (If rural, give location) 911 DAVIS AVE.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If under 24 Hours: Hours / Min.
Female	White	Widow	Dec. 18, 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	KENTUCKY	U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	NONE	NONE	WELFARE Board,	Prince George County

CAUSE OF DEATH

18.

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CHRONIC MYOCARDITIS & MYOCARDIAL DEGENERATION — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO NON-RHEUMATIC

(B) GENERALIZED ARTERIOSCLEROSIS — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) SENILITY

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MALNUTRITION — 1 month

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August 31, 1949, to September 5, 1949, *that I last saw the deceased alive on* September 5, 1949, *and that death occurred at* 5:12 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Melvin M. Borden M. D.	2030 W. Fayette St	9/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 8, 1949	Washington National	Lindenburg, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 6 - 1949	Huntington Williams, M.D.	Francis Gasch - Sons	Hyattsville Md.

VS 150

937

077922

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

60

077922 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) William H. Mayler

2. DATE OF DEATH 9/4/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR STITUTION (If not in hospital or institution, give street address or location) Balto City Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md 7-01
D. STREET ADDRESS (If rural, give location) 3114 E. Monument St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M.	Aug 4 1889	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector
10B. KIND OF BUSINESS OR INDUSTRY Flour Mill
11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME —
14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Minnie Mayler ADDRESS 3114 E Monument

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C. V. disease

DUE TO

(B) Diabetes Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE C. P. Jurbinski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 9/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept 7, 1949
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) Baltimore Md (State)

DATE RECEIVED BY LOCAL REGISTRAR SEP 6 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Ulrich Funeral Home ADDRESS 1698 Edmondson Ave

VS 151

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7923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H NO. B.C 49-1795

Registered No. 977923

1. NAME OF DECEASED (Type or Print): Baby Boy Gibson

2. DATE OF DEATH: 8/25/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Carroll

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.

C. CITY OR TOWN: Westminster (If outside corporate limits, write RURAL and give township)

Length of stay in Baltimore: Yrs. — Mos. — Days 2

D. STREET ADDRESS (If rural, give location): 20 Lemon ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Male	Colored		8/24/49			11 hrs 15 min

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	none	Md.	U.S.A

13. FATHER'S NAME: George HENRY GIBSON

14. MOTHER'S MAIDEN NAME: INEZ OMEGA CHASE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: MOTHER ADDRESS: SAME

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PULMONARY ATELECTASIS

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John F. Strahan M. D.	Univ. Hospital	9/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation		UNIVERSITY MEDICAL SCHOOL	SEP 6, 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 7 - 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

MEDICAL CERTIFICATION

161a

924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077924

TH NO.

NAME OF DECEASED (Type or Print) Clinton B. Pentz

2. DATE OF DEATH 9/5/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4904 Ross Rd.

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 29 03
D. STREET ADDRESS (If rural, give location) 4904 Ross Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Divorced	10/19/1864	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Clerk	Highway Dept Balto City	Balto	Md.

13. FATHER'S NAME Wm H. Pentz

14. MOTHER'S MAIDEN NAME Virginia (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Robt H. Pentz	2816 Evergreen Ave

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

~~DUE TO~~ associated

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral Thrombosis

~~DUE TO~~

(C) Right hemiplegia

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Terminal uremia

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 25, 1949 *to* Sept. 5, 1949 *that I last saw the deceased alive on* Sept 1, 1949 *and that death occurred at* 5 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
L. V. Harbold M. D.	406 Harford Road	9-6-49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	9/7/49	Green Mount	Balto. Md.

DATE RECEIVED BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 7 1949	Huntington Williams, M.D.	Wm Cook Inc	1217 St. Paul St.

VS 150

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7925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

177 Registered No. 077925

RTH NO.

NAME OF DECEASED (Type or Print): Robert Levering Keyser

2. DATE OF DEATH: 9/6/49 11 a.m.

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4709 Roland Ave

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 4704 Roland Ave 27-14

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	12/21/1884	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ford Dewrney Exp.
10B. KIND OF BUSINESS OR INDUSTRY: City of Balto.
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY? Md
13. FATHER'S NAME: Richard Fuller Keyser
14. MOTHER'S MAIDEN NAME: Virginia Rabora
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: High F. B. Kerr ADDRESS: 4704 Roland Ave

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Prostate
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1945 *to* Sept 6, 1949 *that I last saw the deceased alive on* Sept 6 1949 *and that death occurred at* 11.15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: William G. Stelfox M. D.
23B. ADDRESS: 3006 Roland Ave
23C. DATE SIGNED: Sept 6, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/9/49	Green Mount	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 7 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St

VS 150

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7926 ES-123613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0 ✓ 0779.26 Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Alexander Cornish

2. DATE OF DEATH: 9-5-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

Length of stay in Baltimore: 47 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN: Balto.
(If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 2401 Brookfield Avenue (17)

13-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Single	Oct. 8, 1901	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elevin Cornish
14. MOTHER'S MAIDEN NAME: Mary Carroll

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-09-0648
17. INFORMANT: RECORDS* BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Advanced Pulmonary tuberculosis with multiple cavities in the left lung

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO:

(C):

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-9, 19 48, *to* 9-5-, 19 49, *that I last saw the deceased alive on* 9-5-, 19 49 *and that death occurred at* 6:10 *m. from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Cozen M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 9-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 8/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 7 1949
REGISTRAR'S SIGNATURE: Hattie Lee Williams, M.D.
25. FUNERAL DIRECTOR: Wm Brooks
ADDRESS: [illegible] Cary St

13B

927

TH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

81 Registered No. 977927

NAME OF DECEASED (Type or Print) CHARLES LIBMAN

2. DATE OF DEATH 9-6-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

Length of stay in Baltimore — Yrs. — Mon. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND. B. COUNTY Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) WESTMINSTER
D. STREET ADDRESS (If rural, give location) 126 E GREEN ST

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	MAY 29 1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT
10B. KIND OF BUSINESS OR INDUSTRY ?
11. BIRTHPLACE (State or foreign country) NEW YORK CITY, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FAJUSH LIBMAN
14. MOTHER'S MAIDEN NAME HILDA SPILKA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) UNKNOWN (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT PATIENT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 6 DAYS
DUE TO
(B) ADENOCARCINOMA OF BLADDER — 5 YEARS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 9-1-49
19B. MAJOR FINDINGS OF OPERATION Adenocarcinoma of Bladder
20. AUTOPSY? YES ☐ NO ☑
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Aug 30, 1949 to Sept 6, 1949 that I last saw the deceased alive on Sept 6, 1949, and that death occurred at 3:05 p m, from the causes and on the date stated above.

23A. SIGNATURE Richard C. Brack, M. D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 9-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 8, 1949	Washington Cemetery	New York City N.Y.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 7 - 1949
REGISTRAR'S SIGNATURE: Hunterstown Williams, M.D.
25. FUNERAL DIRECTOR AND ADDRESS: David Goodman Sons 1902 Eutaw Place

VS 150

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7928 ✓

BALTIMORE CITY HEALTH DEPARTMENT 413 077928

CERTIFICATE OF DEATH

TH NO. Registered No.

NAME OF DECEASED (pe or Print) Anna Niemur (Nimes)

2. DATE OF DEATH Sept 4-1949

PLACE OF DEATH: Baltimore City, Maryland 2242 Sidney ave

FULL NAME OF SPITAL OR STITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 2242 Sidney ave 75-33

Length of stay in Baltimore 60 yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	White	Widowed	?	72	? ?	? ?

9A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired) Housework
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Lith.
12. CITIZEN OF WHAT COUNTRY? ?

10. FATHER'S NAME ? Mikusauskas
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 216-24-5867
17. INFORMANT Mrs Mag. Ambrose ADDRESS 2242 Sidney ave

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Auricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH 1 week

DUE TO

(B) Hypertension C.V.D. — 3 year

DUE TO

(C) None

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 11, 1949 *to* Sept 13, 1949 *that I last saw the deceased alive on* Sept 13, 1949 *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	1301 Eutaw pl	9-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 7-49	Loudon Park	Frederick ave Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 7-1949	Huntington Williams, M.D.	Joseph Kaminskas Inc	602 Wash. Blvd. 931

VS 150

7929 — BALTIMORE CITY HEALTH DEPARTMENT — 077929

CERTIFICATE OF DEATH

BTH NO. — Registered No.

NAME OF DECEASED (Type or Print): WALLACE KROPOWICZ (emv)

2. DATE OF DEATH: Sept. 5, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 510 S. Monford Avenue 1-03

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 53 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Can Co.

11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — ADDRESS: Mary Kropowicz 510 S Monford Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Leukemia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Dr. J. MacAlpin M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 9th 49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 7 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Fred W Orazewski
ADDRESS: 730 Eastern Ave

VS 151

7930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#43

Registered No. 077930

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Jones

2. DATE OF DEATH 9-6-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Sq. Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 801 Union Ave 13-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		Aug 10 1893	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer

10B. KIND OF BUSINESS OR INDUSTRY R.R. Employee

11. BIRTHPLACE (State or foreign country) Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wm. Jones

14. MOTHER'S MAIDEN NAME Wineholdt, Irig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO 717-07-8680

17. INFORMANT Mrs Jones ADDRESS Same

CAUSE OF DEATH

18.

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — DUE TO

(B) Hypertensive C.V. Disease — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 16 days
(B) years
(C)

MEDICAL EXAMINATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-20, 1949 *to* 9-6, 1949 *that I last saw the deceased alive on* 9-6, 1949 *and that death occurred at* 11 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE A. J. Laham, M.D.

23B. ADDRESS Franklin Sq. Hosp.

23C. DATE SIGNED 9-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Sept 9/49

24C. NAME OF CEMETERY OR CREMATORY Mt Zion

24D. LOCATION (City, town, or county) (State) Freelands, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 7 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Paul E. Clemonts Sons ADDRESS 3657 Edmondson Ave

VS 150

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7931

BALTIMORE CITY HEALTH DEPARTMENT 571.0 077931

CERTIFICATE OF DEATH

RTH NO. 49-07600 Registered No.

1. NAME OF DECEASED (Type or Print): Patricia Ann Gover

2. DATE OF DEATH: Sept. 6, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF OSPITAL OR NSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 415 Forrest St., Balto.-2 Md.

5. SEX: Fe.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 3-23-49
9. AGE (In years last birthday) | If Under 1 Year: Months 5, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wilmer F. Gover
14. MOTHER'S MAIDEN NAME: Lola Burke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wilmer F. Gover — ADDRESS: 415 Forrest St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia, lobular, confluent.
DUE TO
(B) Contributory Cause / Diarrhea, infantile
DUE TO nutritional
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/5/49, 19__, *to* 9/6/49, 19__, *that I last saw the deceased alive on* 9/6/, 1949, *and that death occurred at* 12:15AM, *from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Suwinski M. D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: 9/6/40

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 8 1949
24C. NAME OF CEMETERY OR CREMATORY: Fairview
24D. LOCATION (City, town, or county) (State): Sunnybrook, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Paul E. Schenuit Jr. ADDRESS: 3615-17 Lafayette Ave

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

774

Registered No. 877932

BIRTH NO 49-17413

1. NAME OF DECEASED (Type or Print): Smith, Baby Girl

2. DATE OF DEATH: Sept. 5, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION: St. Joseph's (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: 17 da. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN: Balto. (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1423 N. Bentalou

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug. 19, 1949
9. AGE (In years last birthday) | If Under 1 Year: Months, Days: 17 days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hosp. St. Joseph's, Balto., Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Charles Smith

14. MOTHER'S MAIDEN NAME: Marie McCauley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Wm. L. Smith ADDRESS: 1423 N. Bentalou St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory failure
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 19, 1949 *to* Sept. 5, 1949, *that I last saw the deceased alive on* Sept. 5, 1949, *and that death occurred at* 12:40 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Victor L. Cooper M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: Sept. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 7/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park.
24D. LOCATION (City, town, or county) (State): Frederick Co.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 7 1949
VS 150
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Paul E. Chenowith Jr. ADDRESS: 361-47 Chestnut Ave.

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B-15566
7933
RTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 477933

NAME OF DECEASED (Type or Print): Fred Amend	2. DATE OF DEATH: Sept. 4-1949
PLACE OF DEATH: Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY:
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 76-12
Length of stay in Baltimore: Life (Yrs. Mos. Days)	D. STREET ADDRESS (If rural, give location): 4940 Eastern Ave. No Baltimore City Hospitals (Infirmary) Home
5. SEX: M	6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single	8. DATE OF BIRTH: Nov. 20- 1870
9. AGE (In years last birthday): 78	If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GARDENER	10B. KIND OF BUSINESS OR INDUSTRY: BALTO. CITY Hosp.
11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Amend	14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT'S ADDRESS: Baltimore City Hospitals Records- 4940 Eastern Ave.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — DUE TO

(B) Arteriosclerotic Heart Disease — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-14 *,1935 to* 9-4 *,1949, that I last saw the deceased alive on* 9-4 *,19 49, and that death occurred at* 8.30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Cogen M. D.	23B. ADDRESS: Baltimore City Hospitals	23C. DATE SIGNED: 9-7-49
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE: 9/7/49	24C. NAME OF CEMETERY OR CREMATORY: Baltimore — 24D. LOCATION (City, town, or county): North Ave (State)
DATE RECEIVED BY LOCAL REGISTRAR: SEP 7 - 1949	REGISTRAR'S SIGNATURE: Huntington Williams, M.D.	25. FUNERAL DIRECTOR: Lassahn Funeral Home — ADDRESS: 7401 Belair Rd.

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): FANNIE BLUM DELCHER

2. DATE OF DEATH: Sept. 4, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1840 N. Collington Avenue

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1840 N. Collington Ave.

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 4, 1891

9. AGE (In years last birthday): 57 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel Swoyer

14. MOTHER'S MAIDEN NAME: Fannie Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Frederick G. Delcher ADDRESS: 1840 N. Collington Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia, Caused Directly by — Interval between onset and death: 1 Day

DUE TO

(B) Virus Influenza — 3 Days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* September 2, 1949 *to* September 4 1949 *that I last saw the deceased alive on* Sept 4, 1949 *and that death occurred at* 5 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Albert R. Eisenberg M. D.

23B. ADDRESS: 2025 E. North Ave

23C. DATE SIGNED: 9-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 9/7/49

24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: SEP 7 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC. BALTIMORE - 13, MARYLAND

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7935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331 Registered No. 077935

TH NO.

1. NAME OF DECEASED (Type or Print) LAURA JANE JOHNSON

2. DATE OF DEATH Sept. 5 1949

3. PLACE OF DEATH: Baltimore City, Maryland Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 222 No. Milton Ave.

5. SEX Female

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Jan. 16, 1861

9. AGE (In years last birthday) 88 yrs. | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Maryland Co. (Anne Arundel)

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Chaney

14. MOTHER'S MAIDEN NAME Elizabeth Meeks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. no

17. INFORMANT Mrs. E. T. Foreman ADDRESS Northway Apts. Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 5, 1949 *to* Sept. 5, 1949 *that I last saw the deceased alive on* Sept. 5, 1949, *and that death occurred at* 7:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE William A. Ramsay M. D. | 23B. ADDRESS Union Memorial Hospital | 23C. DATE SIGNED Sept 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/8/49 | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem. | 24D. LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 7 - 1949 | REGISTRAR'S SIGNATURE [illegible] | 25. FUNERAL DIRECTOR WM. J. TICKNER & SONS | ADDRESS Balto., Md.

VS 150

83a

79936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

Registered No. 079936

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MAGGIE M. LAWTON

2. DATE OF DEATH: Sept. 4, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashburton Nursing Home 3520 Hilton Rd.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3520 Hilton Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
female	white	single	July 28, 1870	79 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Secretary (Rtd(	Wholesale Hardware	Baltimore, Md.	

13. FATHER'S NAME: Robert B. Lawton

14. MOTHER'S MAIDEN NAME: Mary C. Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Miss Bertha D. Lawton — ADDRESS: 3520 Hilton Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio - vascular - renal disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hemiplegia - Uraemia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1939, 19__, *to* 9-4, 1949 *that I last saw the deceased alive on* 9-4, 1949, *and that death occurred at* 130 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	36 York Ct.	9/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/7/49	Mt. Olivet Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 7 - 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

121a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5810 Registered No. 077937

BIRTH NO. 937

1. NAME OF DECEASED (Type or Print): Anna Fink

2. DATE OF DEATH: 9/5/49

3. PLACE OF DEATH: Baltimore City, Maryland — Baltimore City

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balt General Hospital

Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-07
D. STREET ADDRESS (If rural, give location): 135 N. Monford Ave #24

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 8/12/1877
9. AGE (In years last birthday): 72
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Schmeiser
14. MOTHER'S MAIDEN NAME: Caroline Brendel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Henry Fink — ADDRESS: 135 N. Montford Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Portal Cirrhosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/22/ 1949, to 9/5 1949, *that I last saw the deceased alive on* 9/5 1949, *and that death occurred at* 2 or 8 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Allyn H. Wood M. D.
23B. ADDRESS: West Baltimore Gen'l Hosp
23C. DATE SIGNED: 9/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 9/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cem.
24D. LOCATION (City, Town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 7 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Miller
ADDRESS: 2334 Jefferson Ave.

VS 150

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0779.38

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

0779.38
Registered No.

1. NAME OF DECEASED (Type or Print): Nickolas Tatarewics

2. DATE OF DEATH: September 5, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1210 South Clinton Street

26 11

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOCTORS HOSPITAL

Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
ale	White	Married		68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pensioned

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cardiac Failure

DUE TO Cardio Vascular Disease

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 3, 1949 *to* Sept 5, 1949 *that I last saw the deceased alive on* Sept 5, 1949 *and that death occurred at* 4:45 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Julius J. Jamar Jr. M. D.

23B. ADDRESS: 2711 Eastern Ave

23C. DATE SIGNED: Sept 6 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 9-9-49

24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus

24D. LOCATION (City, town, or county) (State): Dundalk

DATE RECEIVED BY LOCAL REGISTRAR: SEP 7 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John J. Duda

ADDRESS: 2829 Hudson

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓334X 351

0779.39

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Samella Hendershott

2. DATE OF DEATH Sept. 4-1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1402 E. Chase St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1402 E. Chase

Length of stay in Baltimore 19 Yrs. 10-01 Mos. Days

3. SEX F
6. COLOR OR RACE C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W
8. DATE OF BIRTH 3/5/92
9. AGE (In years last birthday) 57
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife at Home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Franklin Tenn
12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME Henry Gipson
14. MOTHER'S MAIDEN NAME Rachel Porter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mary Hendershott ADDRESS 1402 E. Chase St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(B) Hypertension — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chlorosis ? ?

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 2, 1949, *to* Sept. 4, 1949 *that I last saw the deceased alive on* Sept. 4, 1949, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Wm. de Lon Berry M. D.
23B. ADDRESS 1420 E. Chase
23C. DATE SIGNED Sept 7 '49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept. 8-1949
24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park Inc
24D. LOCATION (City, town, or county) Arbutus (State) Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 7 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Robert E. Williams ADDRESS 1515 McElderry St

VS 150

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~~77940~~ MORECRAFT ~~77940~~

RTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Catherine C. Morecroft

2. DATE OF DEATH 9/5/1949

3. PLACE OF DEATH: Baltimore City, Maryland. 632 Bell St.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE 1692 Bell St.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1032 Bell St. 24-04

5. SEX F | 6. COLOR OR RACE W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 10/21/1882 | 9. AGE (In years last birthday) 66. | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME David Barkelman

14. MOTHER'S MAIDEN NAME Sophia Bauer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT | ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency

DUE TO

(B) Myocarditis

DUE TO

(C) Lymphangitis - Leg.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 10, 1948 *to* Sept 5, 1949 *that I last saw the deceased alive on* Sept 3, 1949 *and that death occurred at* 6:30 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE Chas C. Schemerhorn M. D. | 23B. ADDRESS 1337 S. Charles St. | 23C. DATE SIGNED 9/5/49.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/8/49 | 24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cem | 24D. LOCATION (City, town, or county) (State) Ritchie Highway.

DATE RECEIVED BY LOCAL REGISTRAR SEP 7 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR J. J. Baker & Sons | ADDRESS 1318 Light St.

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59 Registered No. 077941

RTH NO.

1. NAME OF DECEASED (Type or Print) David Tiberdelitt Wilson

2. DATE OF DEATH 9-5-49

3. PLACE OF DEATH: Baltimore City. Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1613 E. Preston St

5. SEX Male
6. COLOR OR RACE Color
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH April 9, 1905
9. AGE (In years last birthday) 44 44
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY SHIPYARD
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME David Wilson
14. MOTHER'S MAIDEN NAME Eva Wilkerson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO.

17. INFORMANT Anna Wilson ADDRESS 1613 E Preston St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Terminal uraemia
DUE TO
(B) Chronic Glomerulonephritis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-2-, 1949 *to* 9-5-, 1949 *that I last saw the deceased alive on* 9-5-, 1949. *and that death occurred at* 10:25 p m., *from the causes and on the date stated above.*

23A. SIGNATURE S. K. Kaan M. D.
23B. ADDRESS St Joseph Hospital
23C. DATE SIGNED 9-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept 8/49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem
24D. LOCATION (City, town, or county) (State) A.A. County Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 7 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mrs Robert A. Elliott + Bryant
ADDRESS 1129 N. Caroline St

VS 150

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B-131154
979-42
TH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

570 5

Registered No. 979-42

1. NAME OF DECEASED (Type or Print): William Moses

2. DATE OF DEATH: Sept-5-1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore: 9yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1422 E. Preston St. 9-09

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 14-1925
9. AGE (In years last birthday): 23
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY: ODD JOBS
11. BIRTHPLACE (State or foreign country): S.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank Moses
14. MOTHER'S MAIDEN NAME: Addie Pugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT (Address): Baltimore City Hospitals Records: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized peritonitis

DUE TO

(B) Intestinal Obstruction

DUE TO

(C) Empyema . Rt.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 8-19-1949
19B. MAJOR FINDINGS OF OPERATION: Drainage of Subdiaphragmatic Abscess
20. AUTOPSY? YES Yes NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-18 , 1949 *to* 9-5 , 1949, *that I last saw the deceased alive on* 9-5 1949, *and that death occurred at* 2.10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 9-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 8 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State): A. A. County Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 7 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Mrs. Bott G. Elliott + Daughter 1129 N. Carolina St.

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077943 — BALTIMORE CITY HEALTH DEPARTMENT — E 8 23.4 — 077943

CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): WALTER EVANS — N-855 0

2. DATE OF DEATH: September 5, 1949

3. PLACE OF DEATH: Baltimore City, Maryland — Balto. Md

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

b. Length of stay in Baltimore: 8 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): Box 99 Old North Point Road

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug. 5-1905
9. AGE (In years last birthday): 44 43
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Contractors
11. BIRTHPLACE (State or foreign country): Prince Edward Co. Va
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Mayor Gains
14. MOTHER'S MAIDEN NAME: Elizabeth Evans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Rose Evans — ADDRESS: Box 99 old North Rd Dundalk

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Ruptured Diaphragm
Multiple rib fractures

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): North of Wise Ave. on New North Point Rd
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 3, 1949 4.00p.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? (driver) Car ran up embankment and overturned

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: William J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 8-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 7 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy S. Wilson
ADDRESS: 1038 Brunt Ave

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5-44 077944 Registered No.

TH NO.

1. NAME OF DECEASED (Type or Print) Rosalie Colombo

2. DATE OF DEATH Sept. 6, 1949

3. PLACE OF DEATH: Baltimore City, Maryland Canada Clinic (If not in hospital or institution, give street address or location)

FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New York B. COUNTY
C. CITY OR TOWN Croton (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) Grand St.

Length of stay in Baltimore: Yrs. Mos. Days

5. SEX female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 47

9. AGE (In years last birthday) 3 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) N.Y.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frank Colombo

14. MOTHER'S MAIDEN NAME Frances ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxia - Respiratory Failure

DUE TO

(B) Congenital heart - Taussig Bing type Tof

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 9/6, 1949 *to* 9/6, 1949, *that I last saw the deceased alive on* 9/6, 1949 *and that death occurred at* 12:10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Harrison C. Spence M. D. | 23B. ADDRESS JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED 9/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24B. DATE Aug-7-49 | 24C. NAME OF CEMETERY OR CREMATORY New York | 24D. LOCATION (City, town, or county) New York State

DATE RECEIVED BY LOCAL REGISTRAR SEP 7-1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | FUNERAL DIRECTOR John B. Connelly - 418 Eastern Ave ADDRESS Balto 24 Md

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

33

077945

Registered No.

1. NAME OF DECEASED (Type or Print) VITO PASTORE

2. DATE OF DEATH 9/5/49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL

Length of stay in Baltimore 37 Yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3406 DU PONT Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Aug. 3 1867	82		2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maintenance	Southern Hotel	Italy	

13. FATHER'S NAME Francesco Pastore

14. MOTHER'S MAIDEN NAME Rose Maria Nanna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	215-01-4399	Kathleen T. Pastore	3406 DuPont Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 31, 1949 *to* Sept 5, 1949 *that I last saw the deceased alive on* Sept 5, 1949 *and that death occurred at* 7 05 P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leon E. Kassel M. D.	Sinai Hospital	9/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 8 1949	Holy Redeemer Cemet.	4430 Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 7 - 1949	Huntington Williams, M.D.	Frank Dellacase	322 S. High St.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

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Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VINCENT J. BERNARDINO Or Beraldino BERARDINO N-991

2. DATE OF DEATH September 6, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2735 W. North Avenue 15 06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	Married	July 16 1895	54	1	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor	City of Baltimore	Italy	U.S.A.

13. FATHER'S NAME: Giuseppe Berardino

14. MOTHER'S MAIDEN NAME: Olimpia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
Yes	1st World War	

17. INFORMANT: Cristina Berardino ADDRESS: 2735 W. North Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Asphyxia	
DUE TO		
ANTECEDENT CAUSES	(B) due to hanging mp	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) Mental depression	2-3 mos.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2735 W. North Avenue

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: September 6, 1949 11a m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Hanged self by rope from pipe in cellar

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Russell S Fisher M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Sept. 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 9 1949	Balti. National Cemetery	5501 Frederick Rd. Balt.Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 7 - 1949	Huntington Williams, M.D.	Francis Bellahoese	322 S High St

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. N-808.0

1. NAME OF DECEASED (Type or Print) FRED FREY

2. DATE OF DEATH September 7, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital

b. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania B. COUNTY Lancaster
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Quarryville
D. STREET ADDRESS (If rural, give location)

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Sept. 12, 1906 | 9. AGE (In years last birthday) 42 yrs, | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10B. KIND OF BUSINESS OR INDUSTRY self employed | 11. BIRTHPLACE (State or foreign country) Altensteig, Germany | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frederick Frey | 14. MOTHER'S MAIDEN NAME Marie Manz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT Carl Reynolds Funeral Home ADDRESS Quarryville Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intracranial Hemorrhage
DUE TO Fracture, pelvis
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Pulaski Highway, Essex, Md. Balto. Co.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept. 1, 1949 5 A. m. | 21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? Tractor & Trailor into Tractor & Trailor

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE W. J. McClafferty M.D. | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED 9-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24B. DATE 9/7/49 | 24C. NAME OF CEMETERY OR CREMATORY Mechanics Grove | 24D. LOCATION (City, town, or county) (State) Lancaster Co., Pa.

DATE RECEIVED BY LOCAL REGISTRAR SEP 7 - 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

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77948

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

077948

Registered No.

1. NAME OF DECEASED (Type or Print) HARLAND EDWARD HUGHSON	2. DATE OF DEATH Sept. 6, 1949
3. PLACE OF DEATH: a. Baltimore City, Maryland	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2323 Longwood St.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
c. Length of stay in Baltimore Yrs. Mos. Days	d. STREET ADDRESS (If rural, give location) 2323 Longwood St. 15-47
5. SEX male / 6. COLOR OR RACE white / 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Mar. 26, 1899 / 9. AGE (In years last birthday) 50 yrs. / If under 1 year: Months Days / If under 24 hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Manager / 10B. KIND OF BUSINESS OR INDUSTRY Construction Co.	11. BIRTHPLACE (State or foreign country) Churchvill, N. Y. / 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Edward Hughson	14. MOTHER'S MAIDEN NAME Fanny E. Hughson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) none / (If yes, give war or dates of service) / 16. SOCIAL SECURITY NO. 215-09-9763	17. INFORMANT Mrs. Vernita M. Hughson / ADDRESS 2323 LongwoodSt.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) 1st attack. — DUE TO

(C) None — DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Sanchin at 12:45 A.m. 9/6/49

INTERVAL BETWEEN ONSET AND DEATH: 6 hours

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/6, 1949, *to* 9/6, 1949, *that I last saw the deceased alive on* 9/6, 1949, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
D. E. Wilson M. D.	1202 St Paul St	9/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	9/8/49	Greenmount Cem.	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 7 - 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

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077949

BIRTH NO.

X 141 X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Expired 077949

Registered No.

1. NAME OF DECEASED (Type or Print) Laura V. Mc Mullen

2. DATE OF DEATH Sept 6 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1128 Poplar Grove St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Harrington Del.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Harrington
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White		Oct 3, 1873	75 73	11	3

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Stores	Maryland	

13. FATHER'S NAME John Laws

14. MOTHER'S MAIDEN NAME Alice V. Hunter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	William Berry	Harrington Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxemia - following loss
DUE TO Tracheotomy tube

(B)
DUE TO

(C) Cancer Tongue — 3 mos. / 3 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY

R B Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
acc.	home	1128 Poplar Grove Street 16/7

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
September 6, 1949 2.45 p m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Suffocated during absence of tracheotomy tube

22. *I hereby certify that I attended the deceased from* Sept 6 19 49 *to* Sept 6 19 49, *that I last saw the deceased alive on* Sept 6, 19 49, *and that death occurred at* 3 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
[signature] M. D.	651 N Bentalou	9/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 9 1949	Stoneywood	Harrington Del.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 7 - 1949	Huntington Williams, M.D.	Howard W Hurd	2503 Edmondson Ave

VS 150

195E

877950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 61.5 877950

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DONALD BLAKE N-861-7

2. DATE OF DEATH Sept. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 917 W. Mulberry Street 18-01

5. SEX Male

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH March 14, 1928

9. AGE (In years last birthday) 23 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Blake.

14. MOTHER'S MAIDEN NAME Agnes Meckle.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) War I

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Catherine Burrell ADDRESS 917 W. Mulberry

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of the heart

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Pine & Saratoga Streets

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY September 5, 1949 Approx 9:30 p.m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE W. J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED 9-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9-8-1949

24C. NAME OF CEMETERY OR CREMATORY Balto. National

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 7 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Mrs. Katie R. Williams ADDRESS 327 N. Schroeder

VS 151

166

77951 JL 131633

BIRTH NO. 48-18462

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

571.0 077951 Registered No.

1. NAME OF DECEASED (Type or Print) Sharon Paul

2. DATE OF DEATH 9-5-49

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

b. Length of stay in Baltimore 1yr (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 845 Lemon St. 18-03

5. SEX F

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH Aug. 24, 1948

9. AGE (In years last birthday) 1 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U

13. FATHER'S NAME Samuel Paul

14. MOTHER'S MAIDEN NAME Inetta Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS B. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Diarrhea & dehyration — DUE TO

(C) — DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
R S Fraber
For: John R. Davis M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ No ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-5-49, 19__, *to* 9-5-49, 19__, *that I last saw the deceased alive on* 9-5, 19 49, *and that death occurred at* 11.15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE C. A. Rogers M. D.

23B. ADDRESS 4940 Eastern Ave.

23C. DATE SIGNED 9-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9-8-1949

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 7 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Mrs. Katie R. Williams 322 N. Soto

VS 150

To be approved by Medical Examiner

119a

077952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

077952
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lillian Seigle

2. DATE OF DEATH 9-3-1949

3. PLACE OF DEATH: Baltimore City, Maryland 324 N. Mount

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 324 N. Mount St.

b. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 324 N. Mount St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 324 N. Mount St. 19-61

5. SEX Female
6. COLOR OR RACE C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Aug. 18, 1907
9. AGE (In years last birthday) 42
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Sparrows Pt. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Horsley.

14. MOTHER'S MAIDEN NAME Alverta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Alverta Horsley. ADDRESS 324 N. Mount

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH 6 mos

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/3 19 49 *to* 9/3 19 49, *that I last saw the deceased alive on* 9/3 19 49, *and that death occurred at* 5 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE O. J. Neill M. D.
23B. ADDRESS 4 E. Madison St
23C. DATE SIGNED 9/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9-8-1949
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary
24D. LOCATION (City, Town, or County) (State) Cedar Hill, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 7 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mrs. Katie R. Williams.
ADDRESS 322 N. Schroeder St

136

077953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33

077953

BIRTH NO. Ellen Davis. Registered No.

1. NAME OF DECEASED (Type or Print) Ellen Davis

2. DATE OF DEATH 9-6-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) President Hosp

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1327 Shields Place
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1327 Shields Place

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Colored	Widow	Jan. 1, 1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Archie Epps.	Ellen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Richetta Lane	1154 Shields Pl

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic pneumonia — Undet.
DUE TO
(B) Cerebral thrombosis — Undet.
DUE TO
(C) Essential hypertension — Undet.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-1, 1949, *to* 9-6, 1949, *that I last saw the deceased alive on* 9-6, 1949, *and that death occurred at* 12:07 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Louis W Leeper M. D.	President Hospital	9-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-9-1949	Mt. Auburn	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 7 - 1949	Huntington Williams, M.D.	Mrs. Katie R. Williams	322 N Schroeder

VS 150

832

077954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0-55

077954

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dorothy Clark

2. DATE OF DEATH: Sept. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 462 Watty Court 11-04

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: Aug. 23, 1941
9. AGE (In years last birthday): 8 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Clarence Clark
14. MOTHER'S MAIDEN NAME: Pearl Hollis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Pearl Clark ADDRESS: 462 Watty Ct.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I

(A) Diphtheria (Laryngeal)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: W. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-9-1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 7 - 1949
REGISTRAR'S SIGNATURE: Pennington-Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Katie R. Williams ADDRESS: 3222 N. Calvert

VS 1ST

10

077955

BIRTH NO. 49-18423

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

763.0

077955 Registered No.

1. NAME OF DECEASED (Type or Print) HELEN ANN NAILL

2. DATE OF DEATH 6 SEPTEMBER 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL
c. Length of stay in Baltimore 15 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 12-8
D. STREET ADDRESS (If rural, give location) 2035 DRUID PARK DRIVE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	W	SINGLE	22 AUGUST 1949		—	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ROCKFORD NAILL
14. MOTHER'S MAIDEN NAME LOUISE COMLEY ✓
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT MOTHER ADDRESS 2035 DRUID PARK DRIVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) BRONCHOPNEUMONIA & ASSOCIATED SEVERE DIARRHEA — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4 SEPTEMBER, 1949, *to* 6 SEPTEMBER, 1949, *that I last saw the deceased alive on* 6 SEPTEMBER, 1949, *and that death occurred at* 7:55 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE William V. Gross, Jr. M. D.
23B. ADDRESS UNION MEMORIAL HOSPITAL
23C. DATE SIGNED 9/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/8/49	Carroll Chapel	Baltimore Co, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 8 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR John J. Cowan & Son ADDRESS Wollins St.

VS 150

119a

077956

BIRTH NO. 49-17726

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

760-5

077956 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Capel (541034)

2. DATE OF DEATH: August 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. 4 years; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-2
D. STREET ADDRESS (If rural, give location): 1818 Laurens Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Negro	Single	August 19, 1949			1 / 31

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME: Johnson Powe

14. MOTHER'S MAIDEN NAME: Verona Capel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: The Johns Hopkins Hospital ADDRESS: 8-22-49

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia due to Intracranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 19, 1949 *to* August 19, 1949, *that I last saw the deceased alive on* August 19, 1949 *and that death occurred at* 9:14 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. Andrews M. D.	601 North Broadway	8-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		Holy Redeemer	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 8 - 1949	Huntington Williams, M.D.		

VS 150

160 a

7779.37 (3 9 2 3 5 8) 7779.37

BIRTH NO. 49-17266

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Zaggery Pride

2. DATE OF DEATH: August 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital
C. Length of stay in Baltimore: 4 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1239 North Bond Street

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: August 16, 1949
9. AGE (In years last birthday) | If Under 1 Year: Months | Days: 4 | If Under 24 Hours: Hours: 2 | Min.: 36
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Eddie Pride
14. MOTHER'S MAIDEN NAME: Dorothy Gordon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: The Johns Hopkins Hospital ADDRESS: 601 N. Broad

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Edema DUE TO Intracranial Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Anoxia DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 16, 1949 *to* August 20, 1949 *that I last saw the deceased alive on* August 20, 1949 *and that death occurred at* 3:00 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: M. Andrews M. D.
23B. ADDRESS: 601 North Broadway
23C. DATE SIGNED: 8-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Hoy Dickerson
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: SEP 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR:
ADDRESS:

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160a

AB-131342
~~27958~~

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. ~~27958~~

1. NAME OF DECEASED (Type or Print): Baby Boy Shindledecker

2. DATE OF DEATH: August 26-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3304 Fait Ave. 26-11

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	White	Single	August 25-1949			1		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Herman Marks
14. MOTHER'S MAIDEN NAME: Delores Shindledecker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals Records- ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

II
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [No] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-25 *, 19* 49 *to* 8-26 *, 19* 49 *, that I last saw the deceased alive on* 8-26 *, 19* 49 *, and that death occurred at* 9.05P *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. L. Cogan M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 8-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated
24B. DATE: 8-31-49
24C. NAME OF CEMETERY OR CREMATORY: B. C. H. Crematory
24D. LOCATION (City, town, or county) (State): 4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

159

AB-131406
G77959
BIRTH NO. 49-18156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

176 G77959
Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Richmond

2. DATE OF DEATH: August 29-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-2
D. STREET ADDRESS (If rural, give location): 123 N. Carrollton Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Negro	Single	August 28-1949			1

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Richmond
14. MOTHER'S MAIDEN NAME: Geraldine Weinstead

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S ADDRESS: Baltimore City Hospitals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES Yes NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-28- , 19 49 to 8-29- , 19 49 *that I last saw the deceased alive on* 8-29- , 19 49 *and that death occurred at* 2.A m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. B. Cozen M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 8-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremated	8-31-49	B. C. H. Crematory	4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR ADDRESS

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977960
AB-131370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-19556

Registered No. 977960

1. NAME OF DECEASED (Type or Print): Baby Girl Lewis

2. DATE OF DEATH: August 28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1303 Pilot Ct.

25.05

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F	White	Single	Aug. 26-1949			2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Lewis
14. MOTHER'S MAIDEN NAME: Doris May Brodsky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S ADDRESS: Baltimore City Hospitals Records-4940 Eastern Ave.

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

(B) fetal Atelectasis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [Yes] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-26- , 1949 *to* 8-28- , 1949 *that I last saw the deceased alive on* 8-28- , 1949 *and that death occurred at* 1.45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: T. S. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 9-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremated	9-2-49	B. C. H. Crematory	4940 Eastern Ave. ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: SEP 8 - 1949
REGISTRAR'S SIGNATURE: Tunstall Williams, M.D.
25. FUNERAL DIRECTOR:

VS 150

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Q779c1

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 49-18302

CERTIFICATE OF DEATH

E 925.1 Q779c1

Registered No.

1. NAME OF DECEASED (Type or Print) Baby Boy Mitchner — N-934.

2. DATE OF DEATH 9-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home Hospital Broadway + Fairmount

c. Length of stay in Baltimore 10 day (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore city
D. STREET ADDRESS (If rural, give location) 24 N. Broadway 6-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	S	aug 29 1949		—10	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Baltimore Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Mitchner

14. MOTHER'S MAIDEN NAME Sara Carton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	No	No

17. INFORMANT E. Harper ADDRESS Church Home

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH 1 min

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Aspiration of Stomach Contents into Trachea + Bronchia

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Non	Non	YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 26, 1949 *to* Sept 4, 1949 *that I last saw the deceased alive on* Sept 3, 19 49, *and that death occurred at* 5:50 p *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Kirk Moore M.D.	Church Home + Hospital	Sept. 5 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	9-5-49	Greenmount Crematory	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 8 - 1949	Thurston Williams, M.D.	John F. Denny, Inc.	

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1951

077902

BIRTH NO. 49-18345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

773 0 077902 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Carrington (487927)

2. DATE OF DEATH: August 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital
c. Length of stay in Baltimore: 2 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-4
D. STREET ADDRESS (If rural, give location): 1901 West Mosher Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Negro	Single	August 27, 1949				13	51

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edgar Crawley
14. MOTHER'S MAIDEN NAME: Dorothy Carrington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: The Johns Hopkins Hospital ADDRESS: 601 N. Broadway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Convulsions
DUE TO
Cause unknown

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 27, 1949 *to* August 28, 1949 *that I last saw the deceased alive on* August 28 1949 *and that death occurred at* 2:54 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: M. Andrews M. D.
23B. ADDRESS: 601 North Broadway
23C. DATE SIGNED: 8-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Hoy Dufour
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: SEP 8 - 1949
REGISTRAR'S SIGNATURE: Functioning for Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

86

Hospital Deaths

BIRTH NO. B.C. 18641

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. (47719)3

1. NAME OF DECEASED (Type or Print): Baby Boy Houston

2. DATE OF DEATH: Sept. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-4
D. STREET ADDRESS (If rural, give location): 259 W. Hoffman St

5. SEX: male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 9/1/49
9. AGE (If under 1 year last birthday) If Under 1 Year: Months / Days; If Under 1 Day: Hours 8 / Min. 12

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Louise Houston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B) Atelectasis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 8 HRS

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/1 *30* 1949 *to* 9/1 1949, *that I last saw the deceased alive on* 9/1 1949, *and that death occurred at* 1:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leon Chandler M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Ivy Burial
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: SEP 8 - 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR:
ADDRESS:

VS 150

159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 17796-4 Registered No. 17796-4

1. NAME OF DECEASED (Type or Print): Maria O. Feddeman

2. DATE OF DEATH: Sept. 6, '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 7 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore . 14-1
D. STREET ADDRESS (If rural, give location): 1400 Linden Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	Dec 26 1872	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Maryland	

13. FATHER'S NAME: William E. Casey

14. MOTHER'S MAIDEN NAME: Mary O. Casey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO

17. INFORMANT: Miss Mary Feddeman ADDRESS: 1400 Linden Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic heart disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Myocardial decomp. + pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 1, 1949 *to* Sept. 6, 1949 *that I last saw the deceased alive on* Sept. 6, 1949 *and that death occurred at* 1:05 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Fred R. McClure M. M. D.	University Hospital	9/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 9/49	Millington	Millington Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 8 - 1949	Huntington Williams, M.D.	Harry H. Lentz	401 Edmondson Ave

VS 150

937

7965 ✓ X E 9-9-9 0779655

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 0779655

1. NAME OF DECEASED (Type or Print) CLIFFORD D. TAYLOR — N-990

2. DATE OF DEATH September 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Found: Recreation Pier, foot of Broadway

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Florida
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jacksonville
D. STREET ADDRESS (If rural, give location) 1437 East 12th Street

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: About 1903
9. AGE (In years last birthday): About 46 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant Seaman
10B. KIND OF BUSINESS OR INDUSTRY: Seagoing
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Isham Taylor
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ?
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ?

17. INFORMANT — ADDRESS: Seaside Funeral Home, Jacksonville, Fla.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Drowning
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): harbor
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Found: Recreation Pier, foot of Broadway
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Found: Sept. 5, 1949 6p m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Found drowned 2/3

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [X].*

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 9/8/49
24C. NAME OF CEMETERY OR CREMATORY: Evergreen Cem.
24D. LOCATION (City, town, or county) (State): Jacksonville, Fla.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Wm. Cook, Inc., 1217 St. Paul St.

VS 151

183 ✓

77966
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 77966

1. NAME OF DECEASED (Type or Print) John Henry Powers,

2. DATE OF DEATH Sept. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2102 Poplar Grove St.
c. Length of stay in Baltimore 74-- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-47
D. STREET ADDRESS (If rural, give location) 2102 Poplar Grove St.,

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	April 14, 1875	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Bd. of Election Supervisors	Baltimore, Md.	

13. FATHER'S NAME: John H. Powers, Sr.

14. MOTHER'S MAIDEN NAME: Annie Marie Reinhardt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Mr. John H. Powers, 3d.	2208 N. Rosedale

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 days
DUE TO
(B) Right Hemiplegia Paralysis — 12 days
DUE TO
(C) Hypertonic Pneumonia — 2 days

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 1949, to Sept 5th, 1949, *that I last saw the deceased alive on* Sept 5, 1949, *and that death occurred at* 3:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hubert E. Tull M. D.	1 Wood Rd.	Sept 6th 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-8-1949	Druid Ridge Cemetery	Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 8 - 1949	Tunstall for Williams, M.D.	G. Howard Strong	3207 W. North Ave.,

VS 150

83a

(7779)67

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

513 (7779)67 Registered No.

1. NAME OF DECEASED (Type or Print): Margaret Williams

2. DATE OF DEATH: Sept. 5 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1736 Ashland Ave.
C. Length of stay in Baltimore: 28 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1736 Ashland Ave. 7-4

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	Colored	Widow	May 10 1874	75				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Charlotte Co Va.	

13. FATHER'S NAME: Jeff Williams

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mary Harris	1736 Ashland Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Myocarditis
DUE TO
(C) Nephritis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August 15, 1949, *to* Sept 5, 1949, *that I last saw the deceased alive on* Sept 5, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert L Lefevre M. D.	522 N. Broadway	9/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 8/49	Mt. Calvary Cem	A. A. County Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 8 - 1949	Huntington Williams, M.D.	Mrs. Robt. G. Elliott & Daughter	112 N. Carlton St.

VS 150

93E

077968

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

077968

Registered No.

1. NAME OF DECEASED (Type or Print): Gertrude E. Monaghan

2. DATE OF DEATH: 9/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5510 Bothill Rd.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
5510 Bothill Lane.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.

D. STREET ADDRESS (If rural, give location): 5510 Bothill Lane. 27-12

5. SEX: F

6. COLOR OR RACE: Wh.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow Since.

8. DATE OF BIRTH: 5/13/1894

9. AGE (In years last birthday): 55

If Under 1 Year: Months / Days

If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief Operator

10B. KIND OF BUSINESS OR INDUSTRY: C & P Telephone Co

11. BIRTHPLACE (State or foreign country): Baltimore Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew J. Monaghan

14. MOTHER'S MAIDEN NAME: Mary E. Sheridan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-05-1215

17. INFORMANT: Mrs. Geo. Edward Day ADDRESS: 5510 Bothill Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Yrs

DUE TO

(B) Tuberculous pneumonia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY. m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1949, *to* September 6, 1949, *that I last saw the deceased alive on* September 4, 1949, *and that death occurred at* 5:15 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Newland Edward Day M. D.

23B. ADDRESS: 4-E-33rd St-18

23C. DATE SIGNED: Sept 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 9/9/49

24C. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

24D. LOCATION (City, town, or County) (State): Govans Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 8 1949

REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.

25. FUNERAL DIRECTOR: J. Tate Bond ADDRESS: 1918 Eutaw Pl.

13B

777969

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 777969

1. NAME OF DECEASED (Type or Print): JOHN WILLIAM CLARK — 2. DATE OF DEATH: September 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-1
D. STREET ADDRESS (If rural, give location): 3919 Southern Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White		1922	27		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Lumber	Penna	

13. FATHER'S NAME: John W Clark Sr.
14. MOTHER'S MAIDEN NAME: Mary M Lawrence

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	World War 2		Samuel Weaver	Waynesburg Pa

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Stab wound of Abdomen
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	3919 Southern Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Sept. 7, 1949 2:00 A. m.?	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Sharp instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
H. J. McClafferty M.D.	[ ] / [X] / [ ]	9-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 10 1949	Waynesburg	Waynesburg Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 8 - 1949	Emerson Williams, M.D.	Howard H. Dent	2502 Edgewood

VS 151

167

077970

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163

077970

Registered No.

1. NAME OF DECEASED (Type or Print) HARRY Clifton Shakespeare

2. DATE OF DEATH Sept 6 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of MD. Hospital

c. Length of stay in Baltimore 52yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 28-2
D. STREET ADDRESS (If rural, give location) 3206 Brightwood Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White.	Married.	June 5, 1888	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B&O Railroad (Last Sept)
10B. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Alamoosa, Col.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Oliver J. Shakespeare
14. MOTHER'S MAIDEN NAME Susan Clark
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Sarah M. Shakespeare ADDRESS 3206 Brightwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3wks
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary infarct right; thrombophlebitis right leg. ?

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 6, 1949, *to* Sept 6, 1949, *that I last saw the deceased alive on* Sept 6, 1949, *and that death occurred at* 7:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Mark E Hall, Jr. M.D.
23B. ADDRESS 710 Md. Ave.
23C. DATE SIGNED 9/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24B. DATE Sept. 9, 1949
24C. NAME OF CEMETERY OR CREMATORY Greenmount Crem.
24D. LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 8 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

VS 150

100 B

give duplicate -

977971

977971

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 977971

1. NAME OF DECEASED (Type or Print): EDITH R. BUSHONG

2. DATE OF DEATH: Sept. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ardleigh Nursing Home 2075 Rockrose Ave.
C. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-4
D. STREET ADDRESS (If rural, give location): 2837 Woodbrook Ave.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Jan. 31, 1874
9. AGE (In years last birthday): 75 yrs. (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Francis I. Dulaney
14. MOTHER'S MAIDEN NAME: Charlotte E. Stier
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.
17. INFORMANT: Miss Olive C. Dulaney - ADDRESS: 2837 Woodbrook Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pernicious Anemia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Sept. 5, 19 49 *to* Sept. 7, 19 49 *that I last saw the deceased alive on* Sept. 5, 19 49 *and that death occurred at* 1:52 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 16 W. Mulberry St.
23C. DATE SIGNED: 9/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/9/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 8-1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

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77972

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

20 - 1

077972

Registered No.

1. NAME OF DECEASED (Type or Print): THOMAS HARROD

2. DATE OF DEATH: September 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-1
D. STREET ADDRESS (If rural, give location): 1354 N. Stricker Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	W	5/1888	61 60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	COALYARD	Md.	U. S. A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		220-09-0771	Mabel Harrod	722 Cumberland St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Myelophthisis anemia	
	Metastatic neoplasm	
	Pneumoconiosis (anth.)	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒	23C. DATE SIGNED
C. L. Jubinski M.D.		9-7-49

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/10/49	Mt. Zion	Md. Anne Arundel Co.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 8 1949	Huntington Williams, M.D.	Wes. H. Nelson	1303 Pennsylvania Ave

55B

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TIFICATE CORRECTED 9-9-49

077973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077973

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Leonard Shipley

2. DATE OF DEATH: Sept. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 81 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Dundalk
D. STREET ADDRESS (If rural, give location): 91 Dundalk Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Nov. 20, 1868	80 Yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George Shipley
14. MOTHER'S MAIDEN NAME: Elizabeth Bowman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Leonard Shipley ADDRESS: 91 Dundalk Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion — Interval between onset and death: 40 min.
DUE TO
(B) Arteriosclerotic Heart Disease Unknown
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Aug 30, 1949
19B. MAJOR FINDINGS OF OPERATION: Adenomatous Hypertrophy of Prostate
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 22, 1949 *to* Sept. 7, 1949 *that I last saw the deceased alive on* Sept. 7, 1949 *and that death occurred at* 7:50 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: James A. Collins 3rd M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: Sept. 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 10, 1949
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Roland L. Fisher ADDRESS: 2112 Dundalk Ave

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077974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 077974

1. NAME OF DECEASED (Type or Print): GERTUDE R. STEINER

2. DATE OF DEATH: SEPT. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3605 HILLSDALE RD.

c. Length of stay in Baltimore: 50 YRS. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 14-1
D. STREET ADDRESS (If rural, give location): 1512 BOLTON ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	SINGLE	AUG 21, 1869	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE		CONN.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
LEWIS STEINER	SARAH S. SMYTH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			AMY L. STEINER	1512 BOLTON ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — Interval between onset and death: few minutes

DUE TO

(B) Cerebral arteriosclerosis — 5 years

DUE TO

(C) Hypertension — 5 years

ANTECEDENT CAUSES —
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH: BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pachymeningitis (atherosclerotic) — 5 years.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov. *, 19*47*, to* Sept 7th *, 19*49*, that I last saw the deceased alive on* Sept 6th *, 19*49*, and that death occurred at* 1:30 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Ferdinand E. Thieme M. D.	1300 N. Calvert St. Balto 2	Sept. 8th 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	9-10-1949	MT. OLIVET	FREDERICK MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 8 - 1949	Huntington Williams, M.D.	H. W. JENKINS & SONS CO.	YORK RD. 4905

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077975

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

077975

Registered No.

1. NAME OF DECEASED (Type or Print): John L. Grube

2. DATE OF DEATH: Sept. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4932 Pennington Ave.,

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 25-5
D. STREET ADDRESS (If rural, give location): 4932 Pennington Ave.,

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Sept. 3, 1890	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician	SHIPYARD	Baltimore, Md.	

13. FATHER'S NAME: John J. Grube

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Theresa Grube, ADDRESS: 4932 Pennington Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: ? 1 year
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 15, 1949 *to* Sept. 7, 1949 *that I last saw the deceased alive on* Aug 5, 1949 *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sidney R. Gilbert M. D.	4700 Pennington Ave	9/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
Burial	9/10/1949	Holy Cross	A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
SEP 8 1949	Huntington Williams, M.D.	Flynn & Fleming, 1426 Light St.

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77976

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

490

Registered No. 077976

1. NAME OF DECEASED (Type or Print): HENRY ALBERT SHRIVER

2. DATE OF DEATH: SEPT 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SOUTH BALTIMORE GENERAL HOSPITAL
c. Length of stay in Baltimore: 10 HOURS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: ANNE ARUNDEL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BRANDON SHORES - CURTIS BAY R.F.D.
D. STREET ADDRESS (If rural, give location): BRANDON SHORES ROAD.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	MARRIED	APRIL 19, 1887	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER	~~APRIL 19, 1887~~	BURRISVILLE Q.A.Co, MD	U.S.

13. FATHER'S NAME: HENRY A. SHRIVER

14. MOTHER'S MAIDEN NAME: ANNIE COMSTOCK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NONE.

16. SOCIAL SECURITY NO.: UNKNOWN.

17. INFORMANT: HENRY A. SHRIVER ADDRESS: BRANDON SHORES

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DEHYDRATION & TOXICITY
DUE TO
(B) RIGHT LOWER LOBE PNEUMONIA
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* SEPT 7, 1949, *to* SEPT 2, 1949, *that I last saw the deceased alive on* SEPT 7 1949. *and that death occurred at* 12 noon., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William B Cooper M. D.	South Balto Gen. Hosp.	9/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	SEPT. 10, 1949	GLEN HAVEN	GLEN BURNIE, MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 8 - 1949	Huntington Williams, M.D.	Thomas W. Singleton	GLEN BURNIE, MD.

VS 150

108

077977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 970.2 - 077977

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Yates SUSAN/ WHEELER — V-971.0

2. DATE OF DEATH September 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1112 GlenEagle Avenue

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-38
D. STREET ADDRESS (If rural, give location) 1112 GlenEagle Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
female	white	widow	July 3,1907	42 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nurse		South Carolina	

13. FATHER'S NAME: D. S. Yates

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			South Balto. Gen'l.Hosp. Balto., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Barbiturate poisoning

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1112 Gleneagle Avenue

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Found: Sept. 7, 1949 2p m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Ingestion of nembutal capsules

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

23A. SIGNATURE W. J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Sept. 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	9/8/49		Columbia, S. C.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 8 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 1ST

correct age is especially important.

163B

077978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 077978

1. NAME OF DECEASED (Type or Print): Thad Clark.

2. DATE OF DEATH: 9-2-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 771 W. Lexington

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 771 W. Lexington St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE. (Where deceased lived. If institution: residence before admission)
A. STATE 771 W. Lexington St. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 4-2
D. STREET ADDRESS (If rural, give location) 771 W. Lexington St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If years, last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
male	C	married	Sept. 10, 1880	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer - B-O.R.R. Retired		Boothford, N. C.	U.S.A.

13. FATHER'S NAME: York mac Clarke.

14. MOTHER'S MAIDEN NAME: Pennie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no		

17. INFORMANT: Mrs. Geneva Clarke ADDRESS 771 W. Lexington St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocardeles — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

(B) acute Arthritis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g.; in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/28 19 49 *to* 9/2/49 19 ..., *that I last saw the deceased alive on* 9/2, 1949, *and that death occurred at* 2:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
David Truemper M. D.	Inw See	9/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Shipment	9-8-1949	Fairmount Cem.	Fairmount S.C.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 8 1949	Huntington Williams, M.D.	Mrs. Katie R. Williams	322 N. Schroeder St.

correct age is especially important. Registrar's

SEP V8 150

93c

77979 J1 - 129329

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

41 6 077979 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Chester Williams

2. DATE OF DEATH: 8-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 20 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-1
D. STREET ADDRESS (If rural, give location): 1510 E. Pratt St.

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 7, 1903
9. AGE (In years last birthday): 46
If under 1 Year: Months / Days
If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ky.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1yr.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Embolic Nephritis — 6 mos.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [ ] No NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-31-49, 19__, *to* Aug. 18, 19 49 *that I last saw the deceased alive on* Aug 18, 19 49 *and that death occurred at* 3.45AM., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 8-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State):
UNIVERSITY MEDICAL SCHOOL AUG 31 1949

DATE RECEIVED BY LOCAL REGISTRAR: SEP - 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health ADDRESS

VS 150

Correct age is especially important. Typewrite or print.

95B

77980 JL - 15714

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

450 0 77980

Registered No.

1. NAME OF DECEASED (Type or Print) Charles Dreifus

2. DATE OF DEATH 8-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore 48 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) B. C. H. Infirmary 26-12

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months Days	If Under 24 Hours: Hours Min.
M	White	Married ?	? ? 1865	84 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Germany	

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: 4940 Eastern Ave. B. C. H. Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Generalized Arteriosclerosis
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [No] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 8-19-04, 19__, *to* Aug. 19, 19 49 *that I last saw the deceased alive on* Aug. 19, 19 49 *and that death occurred at* 4.30pm, *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. A. Rogers M. D.	4940 Eastern Ave.	8-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL AUG 31 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP - 9 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

correct age is especially important. Typewriting is preferred.

97

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 77981

BIRTH NO. BC 49-18511

1. NAME OF DECEASED (Type or Print): Baby Boy Eiler

2. DATE OF DEATH: Sept. 1, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. for Women of Md.
c. Length of stay in Baltimore: Yrs. — Mos. — Days 2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 24
D. STREET ADDRESS (If rural, give location): 415 Hanover St. 26-5

5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Aug. 30, '49
9. AGE (In years last birthday): If Under 1 Year — Months — Days 1 — If Under 24 Hours — Hours — Min. 15 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Edward Joseph Eiler, Jr.
14. MOTHER'S MAIDEN NAME: Margarita Elizabeth Jungblut
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Margarita Eiler — ADDRESS: 415 Hanover St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchopneumonia	1 day 15 hrs. 20 min.
	DUE TO (B) Bilat.	
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C) Maternal - toxemia of preg.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Premature infant.	

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 30, 1949 to Sept. 1, 1949 *that I last saw the deceased alive on* Sept. 1, 1949, *and that death occurred at* 11 07 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: William G. Spencer Jr. M. D.
23B. ADDRESS: Hosp. for Women of Md
23C. DATE SIGNED: 9-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL SEP 2 1949
24D. LOCATION (City, town, or county) (State) ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: SEP - 9 1949
REGISTRAR'S SIGNATURE: Textington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health

VS 150

159

077982

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 077982

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby Boy Rettew

2. DATE OF DEATH: August 31, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital For the Women of Maryland

c. Length of stay in Baltimore: Yrs. — Mos. — Days: one day.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-1
D. STREET ADDRESS (If rural, give location): 4801 Hamilton Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	August 30, 1949		3	18 / 52

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none.	Baltimore, Maryland	

13. FATHER'S NAME: Horace Greely Rettew

14. MOTHER'S MAIDEN NAME: Betty Ray Spickerman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT — ADDRESS
No	None	—

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) (Intrauterine Asphyxia) Anoxia & Resulting Cardiac Vascular Congestion — INTERVAL BETWEEN ONSET AND DEATH: Duration of Life

DUE TO

(B) Premature separation of Placenta — 3

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	—	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	None	None.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	—

22. I hereby certify that I attended the deceased from August 30, 1949 to August 31 1949, that I last saw the deceased alive on August 31, 1949, and that death occurred at 10 1/4 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Hewitt Robert J. M.D. M. D.	Hospital For the Women of Md.	August 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		JOHN HOPKINS MEDICAL SCHOOL SEP 2 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP - 9 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

160 c

correct age is especially important. Physician, please

077933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176 Registered No. 077933

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Billie Jean Ellison

2. DATE OF DEATH Aug. 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hosp. for Women of Md.

c. Length of stay in Baltimore Yrs. 7 Mos. Days 14

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore — 17 14-1

D. STREET ADDRESS (If rural, give location) 1618 Linden Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Female	white	single	Aug 29, 1949			1	22	47

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	—	USA	USA.

13. FATHER'S NAME William Milton Ellison

14. MOTHER'S MAIDEN NAME Virginia Lucille Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		none	Virginia Ellison	1618 Linden Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C) Extreme Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 46 hr. 47 min

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug. 29, 1949 *to* Aug 31, 1949 *that I last saw the deceased alive on* Aug 31, 1949, *and that death occurred at* 5:50 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William S. Spencer, Jr. M. D.	Hosp. for Women of Md.	9-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		JOHN HOPKINS [illegible] SCHOOL	SEP 2 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP - 9 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

correct age is especially important. Physician: please

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 760

Registered No. 27124

BIRTH NO. BC-19292

1. NAME OF DECEASED (Type or Print): Baby Girl Bahr

2. DATE OF DEATH: 9/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.M.H. (Dosp)
C. Length of stay in Baltimore: 17 hours (Yrs. Mos. ~~Days~~)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 404 S. Augusta Ave. 984 S Augusta Street 20-4

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 9/3/49
9. AGE (In years last birthday): If Under 1 Year Months / Days / If Under 24 Hours Hours: 17 Min.: 7
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY: Dependant
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mother ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis, pulmonary — 17 hrs 60
DUE TO
(B) Arterial Hemorrhage — 17 hrs 60
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☑ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Sept. 3, 1949, to Sept 3, 1949, *that I last saw the deceased alive on* Sept 3, 1949 *and that death occurred at* 5:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles I. Henderson M. D.
23B. ADDRESS: Same Town
23C. DATE SIGNED: 9/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL SEP 6 1949
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: SEP 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 077985

BIRTH NO. B.C. 49-19056

1. NAME OF DECEASED (Type or Print): Baby Boy Tyler

2. DATE OF DEATH: 8/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.

C. Length of stay in Baltimore: 19 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto (17) 14-3
D. STREET ADDRESS (If rural, give location): 544 Robert St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	Col.	single	8/27/49.		0 / 2	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Md.	USA

13. FATHER'S NAME: Charles Henry Scott

14. MOTHER'S MAIDEN NAME: Virginia Tyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
no			Mother	same

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/21, 1949 *to* 8/27, 1949 *that I last saw the deceased alive on* 8/29, 1949, *and that death occurred at* 5:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John F. Strahan M. D.	Univ. Hosp.	8/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B		UNIVERSITY MEDICAL SCHOOL	SEP 6 1949

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP - 9 1949	Huntington Williams, M.D.	Commissioner of Health	

Physician: please write legibly; important. Please give correct age if especially

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO BC 49 18603

Registered No. 077986

1. NAME OF DECEASED (Type or Print) Baby Boy Heck

2. DATE OF DEATH 9/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1317 Andre St. 24-1

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH 9/1/49
9. AGE (In years last birthday) If Under 1 Year: Months Days; If Under 24 Hours: Hours 4 Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Heck
14. MOTHER'S MAIDEN NAME Helen Hardy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity
DUE TO Premature Labor

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
4 hrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/1/49, 19__, *to* 9/1/49, 19__, *that I last saw the deceased alive on* 9/1/49, 19__, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE J. F. Hollister M. D.
23B. ADDRESS 1213 Light St
23C. DATE SIGNED 9/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY University Medical School
24D. LOCATION (City, town, or county) (State) SEP 6 1949

DATE RECEIVED BY LOCAL REGISTRAR SEP -9 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Commissioner of Health
ADDRESS

Please answer all questions. Physician: please be especially careful to correct age if important.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. BC-49-17156

1. NAME OF DECEASED (Type or Print): Baby Boy King

2. DATE OF DEATH: 8/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-34
D. STREET ADDRESS (If rural, give location): 1240 Fairby Way Fronting #5

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH: 8/16/49

9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.: 10 days

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Benny King

14. MOTHER'S MAIDEN NAME: Bertha May

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Premature infant ~~Multiple~~ DUE TO (2 pounds - 4oz) — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/20 19 49 *to* 8/26, 19 49 *that I last saw the deceased alive on* 8/26 19 49 *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles J. Blazek M.D. | 23B. ADDRESS: Maryland General | 23C. DATE SIGNED: 9-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL | 24D. LOCATION (City, town, or county) (State): SEP 6 19[illegible]

DATE RECEIVED BY LOCAL REGISTRAR: SEP -9 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Commissioner of Health | ADDRESS

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PLEASE WRITE THE CAUSES OF DEATH CLEARLY. Physician: please write correct age is especially important.

077988

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

16 Registered No. 077988

1. NAME OF DECEASED (Type or Print): ALFRED WELLS, Jr.

2. DATE OF DEATH: Sept. 7th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3712 Pinewood Ave.
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 27-5
D. STREET ADDRESS (If rural, give location): 3712 Pinewood Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	Sept. 26th, 1887	61	11	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Western Auto Supply	Ill.	USA

13. FATHER'S NAME: Alfred Wells

14. MOTHER'S MAIDEN NAME: Mary J. Medford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
yes	World War #1	

17. INFORMANT: Mrs. Alfred Wells — ADDRESS: 3712 Pinewood Ave.

MEDICAL CERTIFICATION

PLEASE WRITE CLEARLY — use only black or blue ink. Print all items. Be sure that the cause of death is correctly stated. Physician: please write carefully; age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: April 1949

DUE TO

(B) ? Lung abscess 1929

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 25, 1949 to ~~Sept~~ Sept 7, 1949, *that I last saw the deceased alive on* Sept 7, 1949, *and that death occurred at* 10 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	M. D.	23B. ADDRESS	23C. DATE SIGNED
H. H. Harbold		4706 Harford Road	9-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	9/10/49	Parkwood	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP - 9 1949	Huntington Williams, M.D.	Lazenby Funeral Home	7401 Belair Rd

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

077989 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRIETT QUINNE

2. DATE OF DEATH 8/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 105 W. 20th St. 12-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C			72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown

10B. KIND OF BUSINESS OR INDUSTRY Unknown

11. BIRTHPLACE (State or foreign country) Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT Unknown ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY. Please write the cause of death in terms of disease and not in terms of mode of dying, such as heart failure, asphyxia, anemia, or uremia. Do not use abbreviations or symbols. Do not state the cause of death as "accident," "homicide," or "suicide" without explaining the nature of the injury. Please report date of birth correctly; if exact age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection of Injury *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE John R Davis M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED 8/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE SEP 6 1949

24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR SEP - 9 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Commissioner of Health ADDRESS

VS 151

077990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 ✓ 077990

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Laura Walton

2. DATE OF DEATH August 25th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1317 Madison Avenue

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 11-4
D. STREET ADDRESS (If rural, give location) 1317 Madison Avenue

5. SEX F

6. COLOR OR RACE C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 1882 ? 1892

9. AGE (In years last birthday) 57 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Newport News, Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Williams — ADDRESS 1317 Madison Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Renal — INTERVAL BETWEEN ONSET AND DEATH 1 yr.

DUE TO

(B) Disease - Hemiplegia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* September 3rd, 1949, to August 22nd, 1949, *that I last saw the deceased alive on* August 22nd, 1949, *and that death occurred at* 1:25 A; m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.

23B. ADDRESS 600 N. Arlington Ave.

23C. DATE SIGNED 8-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY — UNIVERSITY MEDICAL SCHOOL SEP 6 1949

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR SEP -9 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR — Commissioner of Health

ADDRESS

PLEASE WRITE ... correct age is especially important. Physician please write the ...

VS 150

131a

77991 JL - 51537

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-0-0 - 077991

Registered No.

1. NAME OF DECEASED (Type or Print): Elizabeth Webb

2. DATE OF DEATH: 8-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Ave. Baltimore City Hospitals

c. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4017 Hoffman St. 26-12

5. SEX: F

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Wid.

8. DATE OF BIRTH: ? ? ?

9. AGE (In years last birthday): 90 ? (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Perry Miller

14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE CLEARLY. Physician: please write the cause of death in terms which will convey to the undertaker and registrar the correct age is especially important.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion

DUE TO

(B) Arterio sclerotic heart disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ No ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-3-40, 19__, *to* Aug. 28, 19 49 *that I last saw the deceased alive on* Aug. 28, 19 49 *and that death occurred at* 6.50 AM *from the causes and on the date stated above.*

23A. SIGNATURE: H. S. Mozen M. D.

23B. ADDRESS: 4940 Eastern Ave.

23C. DATE SIGNED: 9-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE:

24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State): SEP 7 1949

DATE RECEIVED BY LOCAL REGISTRAR: SEP - 9 1949

REGISTRAR'S SIGNATURE: Hunter Jon Williams, MD

25. FUNERAL DIRECTOR: Commissioner of Health ADDRESS

VS 150

937

077992

JL-124101

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

077992

Registered No.

1. NAME OF DECEASED (Type or Print) Joseph Jones

2. DATE OF DEATH 8-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 70 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-7
D. STREET ADDRESS (If rural, give location) 429 W. 26th. St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Wid.	April 11, 1876	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
		Md.	

13. FATHER'S NAME Alec Jones

14. MOTHER'S MAIDEN NAME Sarah Frances Day

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
		B. C. H. Records, 4940 Eastern Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, with ink or typewriter. In reporting the cause of death, please write the conditions directly leading to death on line (A), and the antecedent causes, if any, on lines (B) and (C). Do not enter the mode of dying, such as heart failure, asphyxia, anemia, etc. Please report only one cause on each line. Physicians are requested to report cause of death as fully as possible, as this information is important. Physician's office address should be given. Please state exact age if under one year.

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Bronchopneumonia	
DUE TO (B)	Arterio sclerotic heart disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Diabetes Mellitus	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ No NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-27-48, 19__, *to* Aug. 23, 19 49 *that I last saw the deceased alive on* Aug. 23, 1949, *and that death occurred at* 12.55 PM *from the causes and on the date stated above.*

23A. SIGNATURE M. D.	23B. ADDRESS	23C. DATE SIGNED
H. A. Ogden	4940 Eastern Ave.	9-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
		UNIVERSITY MEDICAL SCHOOL SEP 7 1949	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP - 9 1949	Huntington Williams, M.D.	Commissioner of Health	

VS 150

61

077993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17-4

077993

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Sarah Davis

2. DATE OF DEATH: Sept. 6 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1712 Madison Ave.

C. Length of stay in Baltimore: 36 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-2
D. STREET ADDRESS (If rural, give location): 1712 Madison Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married	July 27 1909	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	PRIVATE FAMILY	King George C. Va	U. S. A.

13. FATHER'S NAME: Nathaniel Williams

14. MOTHER'S MAIDEN NAME: Annie Pratt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Mr. William Pratt ADDRESS: 1642 N. Fulton Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY. Fill in all blanks. Write the cause of death clearly and correct age is especially important. Physician, please write this

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) General Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 9-29-49 - 9-6-49

DUE TO

(B) Carcinoma of Uterus — 7-1948 - 9-4-9

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
1 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from July 22, 1948 to Sept 6, 1949 that I last saw the deceased alive on 9-5-, 1949 and that death occurred at 3:50 a m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John E. J. Campbell M. D.	639 N. Carey St. Balto. Md.	9-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 9 1949	Mt. Auburn	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP - 9 1949	Huntington Williams, M.D.	Holland Funeral Home	1631 Druid Hill Ave.

VS 150

520 86

48 B

077994

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

17

077994

Registered No.

1. NAME OF DECEASED (Type or Print): MARY E. WRIGHT

2. DATE OF DEATH: Sept. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3118 Abell Ave.

C. Length of stay in Baltimore: 56 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-2
D. STREET ADDRESS (If rural, give location): 3118 Abell Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	July 28, 1881	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	at Home	Philadelphia, Pa.	

13. FATHER'S NAME: Wm. V. Montgomery

14. MOTHER'S MAIDEN NAME: Anna J. Scanlan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
–		–

17. INFORMANT: Mr. James W. Wright — ADDRESS: 3118 Abell Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH INK OR INDELIBLE PENCIL. Physician: please write the cause of death clearly. Exact age is especially important.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

(B) with Metastasis -

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from Aug 2, 1949 to Aug 6, 1949 that I last saw the deceased alive on Aug 7, 1949, and that death occurred at 11 P m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Thomas L. Woodley M. D.	3900 Alameda Blvd	9/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/9/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 9 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

48a

077995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-20 1

077995

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): BESSIE C. McKISSICK

2. DATE OF DEATH: Sept. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 215 Upnor Rd.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 215 Upnor Rd.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	married	Feb. 6, 1881	68 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Pottsville, Pa.	

13. FATHER'S NAME: Charles Franklin Chaundy

14. MOTHER'S MAIDEN NAME: Lydia Ann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
none		none	Mr. Wm. E. McKissick	215 Upnor Rd.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, with ink. Give the cause of death clearly and correct age is especially important. Physician please write the cause of death clearly and

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Sclerosis

DUE TO

(B) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 6th, 1948 *to* Sept 7th, 1949, *that I last saw the deceased alive on* Sept 8th, 1949, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	3033 Wrotham	9/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	9/10/49	Arlington Cem.	Drexel Hill, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 9 - 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 150

94a

077996

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

53

077996

Registered No.

1. NAME OF DECEASED (Type or Print): Nicola Crispino

2. DATE OF DEATH: 9/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2019 E. Fairmount Ave

C. Length of stay in Baltimore: 7 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-4
D. STREET ADDRESS (If rural, give location): 2019 E. Fairmount Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
male	white	married	2/28/1886	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ~~No~~

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Antoinette Crispino ADDRESS 2019 E. Fairmount Ave

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY. Physician please write the cause of death in terms of disease and not in terms of mode of dying, such as heart failure, asphyxia, anemia, or uremia. Please correct age if especially important.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adeno-carcinoma of sigmoid colon.

~~(B)~~ Generalized abdominal metastasis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Sept. 18, 1948	Adeno-carcinoma of sigmoid colon with metastasis in liver & throughout abdomen.	YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept. 15, 1948 *to* Sept. 8, 1949 *that I last saw the deceased alive on* Sept. 8, 1949 *and that death occurred at* 10:20 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip or Antignani M. D.	2942 E. Fayette Street	9/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/12/49	Holy Redeemer	4430 Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 9 - 1949	Huntington Williams, M.D.	John J. Cowan & Son	2201 Hollins St. 46 E

VS. 150

077997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 900.0

077997

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CATHERINE ELIZABETH SCHERER N-870.0

2. DATE OF DEATH Sept. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2400 Ailsa Avenue

c. Length of stay in Baltimore — Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-3
D. STREET ADDRESS (If rural, give location) 2400 Ailsa Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	Oct. 12, 1854	94		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Baltimore, Md.	USA

13. FATHER'S NAME
Henry Scherer

14. MOTHER'S MAIDEN NAME
Catherine Wursten

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		none	Miss Rose Bishop	2400 Ailsa Avenue - 14

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Fracture neck of Femur (Rt)	5 days
DUE TO (B)	Shock	5 days
DUE TO (C)	Bronchio-Pneumonia	3 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

CERTIFICATION APPROVED BY
R S Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Fell down stairs	2400 Ailsa Ave	Home 2400 Ailsa Ave

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
September 2, 1949 4 P m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Fell down stairs.

22. *I hereby certify that I attended the deceased from* Sept 2, 1949, *to* Sept 7, 1949, *that I last saw the deceased alive on* Sept 7, 1949, *and that death occurred at* 4 P. M. *m., from the causes and on the date stated above.*

23A. SIGNATURE	M. D.	23B. ADDRESS	23C. DATE SIGNED
L. W. Bishop		503 S Linden Ave	Sept 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/10/49	Baltimore Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
SEP 9 - 1949	Huntington Williams, M.D.	HENRY SANDER & SONS, INC.

PLEASE WRITE PLAINLY. WITH CAUSES OF DEATH CLEARLY AND CORRECT AGE IS ESPECIALLY important. Physician: please write the cause of death clearly and

VS 150

BALTIMORE - 13, MARYLAND 186a

077998

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170 Registered No. 077998

1. NAME OF DECEASED (Type or Print): ELLA VIRGINIA HEBB

2. DATE OF DEATH: Sept. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harford Nursing Home

C. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-2
D. STREET ADDRESS (If rural, give location): 2410 E. Baltimore St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Widow	July 17, 1865	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Baltimore, Md.	USA

13. FATHER'S NAME: David G. Bickwith

14. MOTHER'S MAIDEN NAME: Mary A. Edgerton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: 4100 Westview Rd. 18
Capt. James S. Hebb

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH INK. Physician: please write the cause of death clearly and correct age is especially important.

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) arteriosclerosis general	10+ years
DUE TO	(B) hemiplegia, right	8 years
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C) cancer, sinulus left breast	3 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	arthritis, hypertrophic, asthenia	8+ years

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no		

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 19 42, *to* 9-7, 19 49, *that I last saw the deceased alive on* 9-7, 19 49, *and that death occurred at* 1:10 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Frank R. Smith, Jr. M. D.	Johns Hopkins Hospital	Sept 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	9/10/49	Greenmount Cemetery	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
~~SEP 9 1949~~	Huntington Williams, MD	HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND 50

AB-77374 0777999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 3 1

0777999 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Howard Courts

2. DATE OF DEATH 9-8-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore — Yrs. Life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-2
D. STREET ADDRESS (If rural, give location) 1168 Sargeant St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Single	June 14-1861	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Courts

14. MOTHER'S MAIDEN NAME Sarah Mason

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Baltimore City Hospitals Records- 4940 Eastern Ave.

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Please write the cause of death clearly and correct age is especially important. Physician:

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular Accident

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-13- , 19 42 *to* 9-8- , 19 49 *that I last saw the deceased alive on* 9-8- , 19 49 *, and that death occurred at* 9.15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE J. L. Rogers M. D.

23B. ADDRESS Baltimore City Hospitals

23C. DATE SIGNED 9-8-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/10/49	London Park	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE Carrington Williams M.D.

25. FUNERAL DIRECTOR E. W. Lamoreaux ADDRESS 1003 W. Balto St.

VS 150

SEP 9- 1949

8 3a

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 19

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Bessie F. Phillips

2. DATE OF DEATH 9-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2100 Madison Ave.

c. Length of stay in Baltimore — Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-2
D. STREET ADDRESS (If rural, give location) 2100 Madison Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
F.	Col.	W	5-29-89	60	3	8		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	None	Maryland	—

13. FATHER'S NAME Thomas Ballard

14. MOTHER'S MAIDEN NAME Alice Franklin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No —	None	G. Franklin Phillips - 1305 N. Bentalou St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Sarcoma of Left Eyelid — INTERVAL BETWEEN ONSET AND DEATH: 3½ mo.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Secondary Anemia — 3wks

DUE TO

(C) —

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
5/23/49	Sarcoma of Left eyelid	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 5-16, 1949 *to* 9-6, 1949 *that I last saw the deceased alive on* 9-6, 1949, *and that death occurred at* 8:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Julius S. White M. D.	1802 Penna Ave	9-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-9-49	Arbutus Memorial	Arbutus, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
SEP 9 - 1949	Kenrington Williams M.D.	Joseph L. Russ, 1200 McCulloh St. Baltimore, Md.

VS 150

PLEASE WRITE PLAINLY, WITH UNFAILING INK. Every item of information should be correctly supplied. Physician: please write the cause of death clearly and correct age is especially important.

53

67800L ✓ 67800L

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Vincent Infussi
2. DATE OF DEATH: 9-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq Hosp.
c. Length of stay in Baltimore: 45 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt
D. STREET ADDRESS (If rural, give location): 3017 Gibbons Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W		June 18, 1879	70	2	20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired SEWRAGE CONTRACTOR	SELF	Italy	U.S.

13. FATHER'S NAME: Dominico Infussi
14. MOTHER'S MAIDEN NAME: Colomba ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
NO	217-07-8275	Angelina Infussi 3017 Gibbons Ave Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Coronary Thrombosis	1 hrs
DUE TO (B)	Hypertensive CV Disease	years
DUE TO (C)		
ANTECEDENT CAUSES I DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-7, 1949 *to* 9-8, 1949, *that I last saw the deceased alive on* 9-8, 1949, *and that death occurred at* 2 a m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
G. J. Laham M. D.	Franklin Sq Hosp.	9-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	September 12/49	(Holy Redeemer Cemetery	4430 Beleir Rd. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 9 - 1949	Huntington Williams, M.D.	Frank Tello Iwell	322 S. High St.

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 45 Registered No.

1. NAME OF DECEASED (Type or Print) Alice Fauntleroy

2. DATE OF DEATH 9-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 565 - Mosher St

C. Length of stay in Baltimore 15 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 14-2
D. STREET ADDRESS (If rural, give location) 565 - Mosher St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
Female	Negro	Widowed	April 15 1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Lacaster Co. Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alfred Reid
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Arteriosclerosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-7- 1949 *to* 9-7- 1949 *that I last saw the deceased alive on* 9-7- 1949 *and that death occurred at* 3:27 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE A. E. Bradyh. M. D.
23B. ADDRESS Provident Hospital
23C. DATE SIGNED 9-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9/10/49
24C. NAME OF CEMETERY OR CREMATORY Lancaster
24D. LOCATION (City, town, or county) (State) Lancaster Co. Va

DATE RECEIVED BY LOCAL REGISTRAR 9-1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Geo. H. Kelson
ADDRESS 1303 Pennsylvania Ave

VS 150

97

078003 CERTIFICATE CORRECTED 9/15/49

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

19-1

078003

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Mary Tonkin

2. DATE OF DEATH Sept 8 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3339 Woodland Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-16
D. STREET ADDRESS (If rural, give location) 3339 Woodland Ave

c. Length of stay in Baltimore 79 years Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	April 29 1898	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Kelston, England	U.S.A.

13. FATHER'S NAME William Liddecoat

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT John H. Tonkin ADDRESS Mr ~~Mrs~~ 3339 Woodland Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: about 6 months

DUE TO

(B) Carcinoma of Abdominal Wall — about 2 ~~6~~ months

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* February 1949 *to* Sept 8 1949 *that I last saw the deceased alive on* Sept 8 1949 *and that death occurred at* 4:25 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Julius C. Bluer M.D.	5356 Reisterstown Rd	9/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 10/49	Druid Ridge	Pikesville, Md. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 9-1949	Huntington Williams, M.D.	Loring Byers	500 Park Heights Ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the cause of death clearly and legibly. Be sure correct age is especially important.

VS 150

53

078004 Dr Roseman ✓ 2687 Wilkens Ave 078004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): RALPH DUKES

2. DATE OF DEATH: Sept. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 739 W. Fayette St.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-2
D. STREET ADDRESS (If rural, give location): 739 W. Fayette St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 8, 1893
9. AGE (In years last birthday): 56
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chemical Operator
10B. KIND OF BUSINESS OR INDUSTRY: Davidson Chemical Co.
11. BIRTHPLACE (State or foreign country): Tenn.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Dukes
14. MOTHER'S MAIDEN NAME: Dona Hicks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Mrs Bertha Dukes, 739 W. Fayette St,

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Cardiac Dilitation — Interval between onset and death: One day
DUE TO
(B) Cardio - Vascular Disease — ?
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 5, 19__, *to* Sept 8, 1949 *that I last saw the deceased alive on* Sept 8, 1949, *and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Harry Eisenman M. D. | 23B. ADDRESS: 9607 Merlen Av | 23C. DATE SIGNED: Sept 9 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal | 24B. DATE: 9/9/49 | 24C. NAME OF CEMETERY OR CREMATORY: Tennessee Georgia Mem. Pk | 24D. LOCATION (City, town, or county) (State): Rossville, Ga.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 9 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1217 St. Paul St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of the cause of death clearly and legibly. correct age is especially important. Physician, please write the c

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078005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO 33 4 Registered No. 078005

1. NAME OF DECEASED (Type or Print): Aida H. Byrd

2. DATE OF DEATH: Sept. 7 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1400 N. Lexington St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-2
D. STREET ADDRESS (If rural, give location): 1400 N. Lexington St.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): aged Womens and aged Mens Homes

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 24 1873
9. AGE (In years last birthday): 75
If Under 1 Year: Months 10 Days 14
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: S. F. Baily
14. MOTHER'S MAIDEN NAME: Katherine Matthews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: L. H. Read ADDRESS: 1400 N. Lexington St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Senile Dementia — INTERVAL BETWEEN ONSET AND DEATH: 10 weeks
DUE TO
(B) Cerebral Arteriosclerosis — 2 years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1949 *to* Sept 9, 1949, *that I last saw the deceased alive on* Sept. 6, 1949, *and that death occurred at* 10.50 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Newland Edward Day M. D.
23B. ADDRESS: 4-E-33rd St - 18
23C. DATE SIGNED: Sept 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial.
24B. DATE: 9/10/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 9 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. V. Lemmon ADDRESS: 4611 Pk. Hgts

PLEASE WRITE PLAINLY, WITH UNFADING INK. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

97

078006 Clem. ✓ 078006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

D ✓

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDGAR J. CLEM

2. DATE OF DEATH 9/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTO GEN. HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 21-2
D. STREET ADDRESS (If rural, give location) 1156 WARD ST.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	WIDOWED	OCT. 29. 1901	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffer	Victor + Pike	Frederick County Md.	

13. FATHER'S NAME Charles Albert Clem

14. MOTHER'S MAIDEN NAME Ann May Turner 1156

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ✓ (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-05-4932

17. INFORMANT Milton Ezra Clem ADDRESS Ward 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ANEURYSM OF THORACIC AORTA — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ARHEROSCLEROSIS (PREMATURE)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. LUNG ABSCESS EMACIATION

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9/7/49	SAME AS ABOVE	YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* JULY 14, 1949, to SEPT 7, 1949 *that I last saw the deceased alive on* SEPT. 7, 1949, *and that death occurred at* 1:50 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William B. Cooper Jr. M. D.	South Balto. Gen. Hosp.	Sept 7, 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	9-9-49	Cedar Hill Cemetery	Anne Arundel

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 9 - 1949	Huntington Williams, M.D.	C. W. Jackowski	703 McHenry St.

VS 150

30 D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

078007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1949

078007

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Mary E. Reese

2. DATE OF DEATH Sept. 8, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1402 William Street

c. Length of stay in Baltimore 51 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24-3
D. STREET ADDRESS (If rural, give location) 1402 William Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	Feb. 4, 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert Foltz	Don't Know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	None	Mrs. Fannie M. Hood.	1705 Olive St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Breast right.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1yr.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Nov 1948	Carcinoma of Right breast with Metastasis	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from July 25, 1949, to Sept. 8, 1949, that I last saw the deceased alive on Sept 7, 1949, and that death occurred at 1:50 A.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
John P. Ulrich, Jr. M. D.	1227 Wash Blvd	9-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 12, 1949	Leden Park	A. A. Co

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 9-1949	Huntington Williams, M.D.	A. Howard Evans	1400 St Charles St

VS 150

50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Write to the cause of death clearly and legibly. correct age is especially important. Physicians: please write the

G78008

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G78008

1. NAME OF DECEASED (Type or Print): Ernest J. Frome

2. DATE OF DEATH: Sept. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1145 Riverside Ave
c. Length of stay in Baltimore: Life — (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 24-2
D. STREET ADDRESS (If rural, give location): 1145 Riverside Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: April 16, 1905
9. AGE (In years last birthday): 44
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping Clerk for G&P Tea Co.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto., Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Ernest C. Frome
14. MOTHER'S MAIDEN NAME: Anna Hogan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-03-3628
17. INFORMANT: Mrs. Anna M. Frome (wife) — ADDRESS: Same

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered or "unknown" stated. Indicate the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: About 2 years
DUE TO
(B) —
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/30, 1949 *to* 9/8, 1949 *that I last saw the deceased alive on* 9/7, 1949 *and that death occurred at* 4:50 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Harry Deiker M. D.
23B. ADDRESS: 1220 Hanover St
23C. DATE SIGNED: 9/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 12, 1949
24C. NAME OF CEMETERY OR CREMATORY: London Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 9 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: O. Howard Evans — ADDRESS: 1400 S. Charles St, Balto 30, Md. 13B

VS 150

078009

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 078009

Registered No.

1. NAME OF DECEASED (Type or Print) JOHN M. STADTER

2. DATE OF DEATH 9-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2232 BANK ST.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2232 BANK ST. 1-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	WIDOWED	10/12/1864	84		

10A. USUAL OCCUPATION (Give kind of work, even during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
POLICE MAN	RETIRED	GERMANY	U.S.A.

13. FATHER'S NAME GEORGE STADTER

14. MOTHER'S MAIDEN NAME MARYANNA WINKLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
NO	—	

17. INFORMANT MARY DILEGGI ADDRESS SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Senility
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: —

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/4/47, 19—, *to* 9/7, 1949, *that I last saw the deceased alive on* 9/7, 1949, *and that death occurred at* 11 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Sigmund R. Nowak M.D.	408 S. Patterson Pk. Ave.	9/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	9/10/49	HOLY REDEEMER	BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 9 - 1949	Huntington Williams, M.D.	WILLY & ZEILER	BALTO.

VS 150

162 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct as near as may be. Please write the cause of death clearly and legibly. Correct age is especially important. Physicians: please write

Dr. Stevens
2878 Harford Rds

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59 ✓ 078010

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print) MARY BUETTNER

2. DATE OF DEATH 9/6/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1508 Cliftview Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — B. COUNTY: 1508 Cliftview Ave Balto Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 8-5
D. STREET ADDRESS (If rural, give location): 1508 Cliftview Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F M	White	Widow	Sept 21, 1867	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Marie Ilgenfritz — ADDRESS: 1508 Cliftview Ave

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be completed. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 7 D

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Mitral Regurgitation Decompensated — 1 Day
DUE TO Arteriosclerosis Hypertension — 14 Y
(C) Chronic Interstitial Nephritis — 14 Y

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 3, 1949, to Sept 6, 1949, *that I last saw the deceased alive on* 9-6-, 1949, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
F. C. A. Stevens M. D.	2878 Harford Rd	9-8 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/10/49	Holy Redeemer	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 9 - 1949	Huntington Williams, M.D.	Leonard J. Ruck	5305 Harford Rd

VS 150

1310

Dr. Crott
Parkville

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. | Registered No. 07801

1. NAME OF DECEASED (Type or Print): William E. Greenwood

2. DATE OF DEATH: Sept 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6109 Sefton Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 6109 Sefton Ave Balto (14) Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Maryland
D. STREET ADDRESS (If rural, give location) 6109 Sefton Ave 27-5

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Married	May 23, 1901	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ass't Mgr Fidelity
10B. KIND OF BUSINESS OR INDUSTRY: Deposit

11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William J. Greenwood
14. MOTHER'S MAIDEN NAME: Henrietta Cross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Mrs. Myrtle Greenwood 6109 Sefton Av

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Give correct age is especially important. Physicians: please write the

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/29 1949 to 9/8, 1949, *that I last saw the deceased alive on* 9/8, 1949, *and that death occurred at* 1:45 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harold A. Crott, M. D.
23B. ADDRESS: 8100 Harford Rd
23C. DATE SIGNED: 9/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/10/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 9 1949
REGISTRAR'S SIGNATURE: Ernest G. Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Leonard J. Ruck 5305 Harford Rd

VS 150

94a

078012 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97 ✓ 078012 Registered No.

1. NAME OF DECEASED (Type or Print): Philomena Nina Lederer — N-971.0
2. DATE OF DEATH: Sept. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 901 Lakedrive [illegible]. Ap't 5c Riveria
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-1
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): Ap't. 5C Riveria, 901 Lakedrive

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	S	Jan 28-1909	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Xavier Lederer
14. MOTHER'S MAIDEN NAME: Theresia 4904 Clemont Balto 6.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Anna Weiss — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Nembutal poisoning
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Ap't. 5c Riveria, 901 Lakedrive
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 8, 1949 ? m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Ingestion of sleeping pills

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
cremation	Sept 10-49	Greenmount	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 9 - 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Funk — ADDRESS: 1330 Gorsuch

VS 151

163 B ✓

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

078013

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

Registered No. 078013

1. NAME OF DECEASED (Type or Print) Ada Elizabeth Elliott

2. DATE OF DEATH Sept. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 319 S. Gilmor St.
c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
19-3
D. STREET ADDRESS (If rural, give location) 319 S. Gilmor St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Apr. 21, 1897	52	4 / 16	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Geisel

14. MOTHER'S MAIDEN NAME Elizabeth Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-01-6247

17. INFORMANT Elizabeth Miller ADDRESS

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made for each item. Write the causes of death clearly and legibly. Omit terms of indefinite meaning, such as "old age," "debility," etc. Give the correct age if especially important. Physicians: please write the cause of death in terms which will convey a definite picture of the pathological condition.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardio vascular disease — Interval between onset and death: 1 yr.
DUE TO
(B) Cerebral hemorrhage — 1 day
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9/2, 1948 *to* 9/7, 1949 *that I last saw the deceased alive on* 9/7, 1949 *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Benjamin Miller M. D.	1030 Calhoun Ave	9/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 10, 1949	Loudon Park	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 9 - 1949	Huntington Williams, M.D.	Fred H. Cole	1913 W. Baltimore St

VS 150

931

078014

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

078014

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Cecelia Buckner

2. DATE OF DEATH 9/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good SAMARITAN HOME

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-2
D. STREET ADDRESS (If rural, give location) 278 Carey St.

5. SEX Female
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH Dec. 1859
9. AGE (In years last birthday) 89 — If under 1 year: Months, Days; If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Geo. W. Taylor

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Pearl L. Beckman — 3044 Edmondson Ave ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis and myocardial degeneration - not rheumatic — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

(B) generalized arteriosclerosis — ?

DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1949, *to* September 8, 1949, *that I last saw the deceased alive on* Sept 8, 1949, *and that death occurred at* 9.30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Melvin N. Borden M. D.
23B. ADDRESS 2030 W. Fayette St
23C. DATE SIGNED 9/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9/12/49
24C. NAME OF CEMETERY OR CREMATORY Western
24D. LOCATION (City, town, or county) (State) Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 9 - 1949
REGISTRAR'S SIGNATURE Huntington Hillsman, M.D.
25. FUNERAL DIRECTOR Harry H. Mintzer 4101 ADDRESS Edmondson Ave

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Give the causes of death clearly and legibly. Use correct age is especially important. Physicians: please write the cause of death clearly and legibly.

15 V To Be okayed By

Q78015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E903.0 Med Ex Office

Registered Q78015

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mabel McBurney — N-870.0 — 2. DATE OF DEATH 9/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Severn
D. STREET ADDRESS (If rural, give location) Severna Park

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Married	6/24/1873	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife.		Pa.	

13. FATHER'S NAME Samuel Graham

14. MOTHER'S MAIDEN NAME Mary Hamilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	Mrs Judd	3159 Elmora Ave

MEDICAL CERTIFICATION

Please write plainly with pen or pencil. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Fractured Hip
DUE to A fall at home.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
for John R. Davis per
R S Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/27 + 8/12/49	Fracture lt. Femur	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Accident	Home	Severna Park. McKenzie Rd. 52-00

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
7/21/49 9:30 A.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Fell at home - to floor

22. *I hereby certify that I attended the deceased from* 7/21/49, 19__, *to* 9/9/49, 19__, *that I last saw the deceased alive on* 9/9/49, 19__, *and that death occurred at* 7:31 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jerome Pleet M. D.	1213 Light St.	9/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or County) (State)
Burial	9/12/49.	Parkwood	Parkville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 10 1949	Registrar for Baltimore, Md.	Williams & Dash	1217 E. Lanvale St

VS 150

186a

Q78016

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. Q78016

1. NAME OF DECEASED (Type or Print): MARY MCHARDY

2. DATE OF DEATH: September 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3239 Eastern Avenue
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 744 Poplar Grove Street

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Feb.2,1889
9. AGE (In years last birthday): 60 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10B. KIND OF BUSINESS OR INDUSTRY: Baltimore Luggage Co.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James P. McHardy
14. MOTHER'S MAIDEN NAME: Mary A. Kilbride
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 214-01-7288
17. INFORMANT — ADDRESS: Isabell Harris, 5201 Beaufort Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-Vascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: W. J. McClafferty, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Sept. 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/12/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 151

PLEASE WRITE PLAINLY, with pen, and do not use abbreviations. In describing the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

G78017

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

41-6

G78017

Registered No.

1. NAME OF DECEASED (Type or Print) — Myrtle M. Potts

2. DATE OF DEATH — 9/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — Maryland General
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Baltimore 21-01
D. STREET ADDRESS (If rural, give location) — 1130 Ridgely Lt # 3s

5. SEX — Female
6. COLOR OR RACE — White
7. ~~SINGLE~~, MARRIED, WIDOWED, DIVORCED (Specify) — Married
8. DATE OF BIRTH — 7/13/00
9. AGE (In years last birthday) — 50
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — Housewife
10B. KIND OF BUSINESS OR INDUSTRY — At Home
11. BIRTHPLACE (State or foreign country) — Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME — Owen A. Hartlove
14. MOTHER'S MAIDEN NAME — Blanche Belt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Albert W. Potts
ADDRESS — 1130 Ridgely St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Ventricular fibrillation c
DUE TO Decompensation
(B) Rheumatic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — Laparotomy & splenectomy, left lobar pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [x] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/3, 1949 to 9/9, 1949 *that I last saw the deceased alive on* 9/9, 1949 *and that death occurred at* 12 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE — Charles J. Blazek M.D.
23B. ADDRESS — Maryland General
23C. DATE SIGNED — 9/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) — Burial
24B. DATE — 9/13/49
24C. NAME OF CEMETERY OR CREMATORY — London Park
24D. LOCATION (City, town, or county) (State) — Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR — SEP 10 1949
REGISTRAR'S SIGNATURE — Huntington Williams, M.D.
25. FUNERAL DIRECTOR — [illegible]
ADDRESS — [illegible] 127 St. Paul St.

VS 150

108

Please write plainly with pen or pencil and make no erasures. Physicians: please write the causes of death clearly and legibly. Be sure that the age is entered for each person, and that the correct age is especially important.

(7)78018

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 10

Registered No. (7)78018

1. NAME OF DECEASED (Type or Print) ELSIE WINTER RADCLIFFE

2. DATE OF DEATH 8 SEPT 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 9-03
D. STREET ADDRESS (If rural, give location) 706 E. 33rd ST. BALTIMORE

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	W	19 APRIL 1892	57 56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	BALTIMORE	USA

13. FATHER'S NAME: CHARLES W. WINTER

14. MOTHER'S MAIDEN NAME: MARIA MOLIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: SON, GEORGE G. RADCLIFFE — ADDRESS: SAME

MEDICAL CERTIFICATION

Please write plainly, with ink. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic heart disease 25 yrs

DUE TO c MS, AS, Pul. edema.

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8 SEPT 1949 *to* 8 SEPT 1949 *that I last saw the deceased alive on* 8 SEPT 1949 *and that death occurred at* 10:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Merrill F. Neeson M.D.	Union M. Hosp.	9-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/12/49	Windsor	Windsor Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 10 1949	Huntington Williams M.D.	Wilbur Cook Inc	1217 Hollins St

VS 150

92 B

G78019

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G78019

1. NAME OF DECEASED (Type or Print): Chastine Ware

2. DATE OF DEATH: 9-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oak Grove
D. STREET ADDRESS (If rural, give location):

5. SEX: M.
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 28, 1911
9. AGE (In years last birthday): 37 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Daniel Ware
14. MOTHER'S MAIDEN NAME: Annie Squirrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Annie Ware — ADDRESS: Oak Grove, Va.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Status asthmaticus — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture dislocation of vertebra — 18 yrs.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/26, 1949, *to* 9/8, 1949, *that I last saw the deceased alive on* 9/8, 1949, *and that death occurred at* 3 55 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lucius A. Logan M. D.
23B. ADDRESS: Provident Hospital
23C. DATE SIGNED: Sept. 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-11-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cem
24D. LOCATION (City, town, or county) (State): Oak Grove, Westmoreland Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: M. O. Francis A. Hensley
ADDRESS: 578 W. Biddle St

VS 150

112

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

G78020

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

330 Registered No. G78020

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HESTER PAYNE

2. DATE OF DEATH September 8, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 256 Pine Street 4-0 Y

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Married		75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Hester Bowbey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Mr. William Payne 256 N. Pine St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Embolus
DUE TO
(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Subarachnoid Hemorrhage

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE W. D. McCafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED 9-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9-112-49

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 10 1949

REGISTRAR'S SIGNATURE Wallington Williams, MD

25. FUNERAL DIRECTOR Mrs. Frances A. Hemsley

ADDRESS 578 W. Biddle

VS 151

83a

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and legibly. Be sure correct age is especially important.

G78021

2843 St. Paul St

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G78021
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN G. COBLE.

2. DATE OF DEATH: Sept 9, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 414 W. 25th St.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. 50 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 414 W. 25th St. 14-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	white	married	Aug 23, 1866	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Brakeman
10B. KIND OF BUSINESS OR INDUSTRY: Penna R.R.
11. BIRTHPLACE (State or foreign country): Penna
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Noah Coble
14. MOTHER'S MAIDEN NAME: Sarah Smith
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Clara C. Coble ADDRESS: 414 W. 25th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO
(B) Arteriosclerotic heart disease — 7 to 10 yrs
DUE TO
(C) Diabetes mellitus. — ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypertensive encephalopathy — 9 yrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1938, *to* 9 Sept 1949, *that I last saw the deceased alive on* 9 Sept 1949, *and that death occurred at* 1:25 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Fred B Coble Jr M. D.
23B. ADDRESS: 2843 St Paul St
23C. DATE SIGNED: 10 Sept 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 12/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount
24D. LOCATION (City, town, or county) (State): York Pennsylvania

DATE RECEIVED BY LOCAL REGISTRAR: SEP 10 1949
REGISTRAR'S SIGNATURE: Lester Williams, M.D.
25. FUNERAL DIRECTOR: Lucian E. Donovan ADDRESS: 3818 Roland Ave

VS 150

61

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Statement of age is especially important.

Q78022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. Q78022

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna L Price

2. DATE OF DEATH: Sept. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 E. Montgomery St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-01
D. STREET ADDRESS (If rural, give location): 36 E. Montgomery St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Female	White	Married	April 19, 1916	33				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Penna	

13. FATHER'S NAME: John Wisnieski

14. MOTHER'S MAIDEN NAME: Mary Piersa

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT: William H. Price — ADDRESS: 36 E. Montgomery

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ① Cystadenoma papillary ovary
DUE TO ② Colloid carcinoma of large bowel

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION: ① Cystadenoma papillary ovary ② Colloid carcinoma of large bowel

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 6, 1949 *to* Sept. 8, 1949 *that I last saw the deceased alive on* Sept. 8, 1949 *and that death occurred at* 1:35 *Am., from the causes and on the date stated above.*

23A. SIGNATURE: Marion C. Insley Jr. M. D.

23B. ADDRESS: 1213 Light St.

23C. DATE SIGNED: 9/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE: Sept 12 1949

24C. NAME OF CEMETERY OR CREMATORY: Holy Cross

24D. LOCATION (City, town, or county) (State): Ritchie Highway

DATE RECEIVED BY LOCAL REGISTRAR: SEP 10 1949

REGISTRAR'S SIGNATURE: Deputy for Williams, M.D.

25. FUNERAL DIRECTOR: John F. Kenny Inc — ADDRESS: 715 Light St

VS 150

46E

I hereby write the causes of death clearly and legibly. Physicians: please write especially important. Be correct age in

078023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

42° 1

078023

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ellen Mentzer

2. DATE OF DEATH: Sept. 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2900 Inglewood Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2900 Inglewood Ave. 27-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	May 17, 1880	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home		Baltimore, Md.	

13. FATHER'S NAME: John "". Beever

14. MOTHER'S MAIDEN NAME: Anna Laurie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No.		

17. INFORMANT: Edward Mentzer — ADDRESS: 7402 Park Drive

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis.

DUE TO

(B) Arteriosclerosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

CERTIFICATION APPROVED BY

R S Faber M. D.

CHIEF OR ASST. MEDICAL EXAMINER

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 8, 1949 *to* Sept 8, 1949 *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Albert C. Herrmann M. D.	6804 Old Harford Rd.	9-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 12, 1949	Moreland Memo. Park,	Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR — ADDRESS
SEP 10 1949	Huntington Williams, M.D.	Ullrich Funeral Home 2008 Orleans St.,

VS 150

94a

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G78024

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G78024

Registered No.

1. NAME OF DECEASED (Type or Print): MRS. MARGARET SCHLUDERBERG

2. DATE OF DEATH: 9-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Calvert & 33rd Sts.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 27-20
D. STREET ADDRESS (If rural, give location): 6602 Park Heights Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	White	Widow	April 4, 1869	80	-	-

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Baltimore, Md	USA

13. FATHER'S NAME: Theodore C. Maasch

14. MOTHER'S MAIDEN NAME: (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	No	None

17. INFORMANT: Mr. Wm F. Schluderberg; ADDRESS: 39 E. Fenchurch

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Unknown Cause~~ Pulmonary Embolism

DUE TO

(B) Virus Pneumonia

DUE TO

(C) ASHD & HCVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Osteoarthritis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from ____, 19__, to August 7, 1949, that I last saw the deceased alive on Aug. 7, 1949, and that death occurred at 8:30 P m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Richard K Beach M. D.	Union Memorial Hospital	9-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept-10-1949	Oak Lawn Cemetery	Eastern Ave & North Point Rd.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 10 1949	Hunter Williams, M.D.	Stewart & Mowen Company	108 W. North Ave City #1

VS 150

937

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

Q78025

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

No. 1

Q78025

Registered No.

1. NAME OF DECEASED (Type or Print): Dean Harper Collier

2. DATE OF DEATH: 9/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2611 Huntington Ave
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Harrisburg R. 4.
D. STREET ADDRESS (If rural, give location): 240 Briggs

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Divorced	Mar. 24, 1885	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
mail clerk	State of Pa.	Marysville, Pa.	

13. FATHER'S NAME: Zacharia T. Collier

14. MOTHER'S MAIDEN NAME: Sarah Dessinger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Mrs. Mabel Collier	2611 Huntingdon Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease — DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
C. J. Sabusky M.D.		9/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Removal	9/11/49		Marysville, Pa.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 10 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS 151

266 98

94a

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

078026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5604

078026

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HENRY MCCORMICK

2. DATE OF DEATH Sept. 7, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 625 W. Biddle Street 17-31

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Oct. 27, 1917
9. AGE (In years last birthday): 31
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

8a. Length of stay in Baltimore: Yrs. / Mos. / Days

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): skilled laborer
10B. KIND OF BUSINESS OR INDUSTRY: MFG. CROSS BARS TELEGRAPH POLES

11. BIRTHPLACE (State or foreign country): Sanford, North Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John McCormick

14. MOTHER'S MAIDEN NAME: Bessie Herrington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Thomas McCormick ADDRESS: 912 W. Mulberry St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Abdominal hemorrhage, due to
DUE TO Rupture of spleen.
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A), STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Atelectasis of lungs.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Shipped
24B. DATE: 9-10-49
24C. NAME OF CEMETERY OR CREMATORY: Southern Pine N.C.
24D. LOCATION (City, town, or county) (State): Southern Pines N.C.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams
ADDRESS: 322 N. Schroeder St.

VS 151

90855

75c

Please write the causes of death clearly and legibly. Physicians: please write the cause correct age is especially important.

078027

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-20-D

078027

Registered No.

1. NAME OF DECEASED (Type or Print) Frank Burrs

2. DATE OF DEATH Sept 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Halsted 28

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-01
D. STREET ADDRESS (If rural, give location) 845 W. Fayette St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (If under 1 year, last birthday) Years	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	Colored	Married	10-15-93	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur	Domestic	Maryland	

13. FATHER'S NAME Richard Burrs

14. MOTHER'S MAIDEN NAME Mary Pilgrim

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I (A)	Congestive Heart Failure	
DUE TO (B)	Arteriosclerosis Arteriosclerotic Heart Disease	
DUE TO (C)	also suffered Carcinoma of Larynx -	

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Sept 6, 1949	Carcinoma of Larynx.	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-5- 19 49 *to* 9-7- 19 49 *that I last saw the deceased alive on* 9-7- 19 49 *and that death occurred at* 3:10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Newton D Archer M. D.	JOHNS HOPKINS HOSPITAL	9-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	9-11-49	Mt. Auburn Cem	Balto	Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 10 1949	Huntington Williams, M.D.	Mr Katie R. Williams	322 N Schroeder St

correct age is especially important. Physicians: please write

VS 150

47a

CERTIFICATE CORRECTED 9/19/49

Q78028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. Q78028

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Walter C. Burchell, Jr.

2. DATE OF DEATH: Sept. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 115 W. Mulberry St. 4-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	March 1908	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer ?		Dover, N. J.	U.S.A.

13. FATHER'S NAME: Walter C. Burchell

14. MOTHER'S MAIDEN NAME: Hester Crane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
Yes	World War II	

17. INFORMANT: Walter C. Burchell, ADDRESS: Dover, N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculous pneumonia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER [X] / MEDICAL INVESTIGATOR	23C. DATE SIGNED
W. J. McLafferty M.D.		Sept. 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24C. LOCATION (City, town, or county) (State)
Removal	Sept 12/49	Pleasant Hill Cemetery	~~Baltimore~~ Parkville Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 11 1949

REGISTRAR [illegible] Parkville, Md

25. FUNERAL DIRECTOR: Henry H. Jenkins, Sons ADDRESS: 4405 York Rd.

13 B

VS 151

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G78029 BALTIMORE CITY HEALTH DEPARTMENT G78029

CERTIFICATE OF DEATH

BIRTH NO 177 Registered No.

1. NAME OF DECEASED (Type or Print) HENRY, Mr. Edward

2. DATE OF DEATH 9-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Catonsville Dist.
D. STREET ADDRESS (If rural, give location) 3019 FOREST AVE #28

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M	W	MARRIED	Aug 11 1884	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owner
10B. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Henry
14. MOTHER'S MAIDEN NAME Dellie Welsh
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT'S ADDRESS Mrs Edw L Henry Catonsville Md

MEDICAL CERTIFICATION

(Physicians: please write correct age is especially important.)

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARCINOMA OF PROSTATE WITH METASTASIS — INTERVAL BETWEEN ONSET AND DEATH: 9 yrs
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0	0	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
0	0	0

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
0 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	0

22. I hereby certify that I attended the deceased from 8-22 1949 to 9-8 1949 that I last saw the deceased alive on 9-8 1949, and that death occurred at 11 45 A m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Stanley B. Braham M.D.	SINAI HOSPITAL, BALTIMORE	9-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-12-49	Calvert	Baltimore.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
SEP 11 1949	Curtis Williams, M.D.	George A Finley	Catonsville

VS 150

5 1 B

BIRTH NO. G78030

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

600.0 G78030

Registered No.

1. NAME OF DECEASED (Type or Print): Miss Anna Kelly

2. DATE OF DEATH: 9-9-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 19-04
D. STREET ADDRESS (If rural, give location): 1721 Hollins St. - Balto. 23, Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	Single	11-21-73	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Saleslady	DEPT. STORE	Balto.	

13. FATHER'S NAME: Thomas E. Kelly

14. MOTHER'S MAIDEN NAME: Bridget Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No	None	James E. Kelly Jr. 5535 Ogontz Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gall Bladder Empiema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Pyelo Nephritis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August 25, 1949, to Sept. 9, 1949, *that I last saw the deceased alive on* Sept. 9, 1949, *and that death occurred at* 12:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. J. Castellano M. D.	Bon Secours Hospital	Sept. 9-1949.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, Town, or county) (State)
Burial	9-12-49	Cathedral	Baltimore

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 11 1949	Huntington Williams, M.D.	George A. Farley	Fulton Ave. & Fayette St.

correct age is especially important. If uncertain, please

VS 150

434 63

127a

AB-131679 G78031

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G78031

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Meyer Eisner

2. DATE OF DEATH: 9-9-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 510 N. Gay St.

5. SEX: M

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: June 17- 1883

9. AGE (In years last birthday): 66 (If under 1 Year: Months Days; If under 24 Hours: Hours Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor

10B. KIND OF BUSINESS OR INDUSTRY: SELF

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Hyman Eisner

14. MOTHER'S MAIDEN NAME: Ida ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Baltimore City Hospitals Records; ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Lung Abscess

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardio Vascular Disease

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Hypernephroma

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-7- , 1949, *to* 9-9- , 1949 *that I last saw the deceased alive on* 9-9- , 1949, *and that death occurred at* 4.50 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Dozer M. D.

23B. ADDRESS: Baltimore City Hospitals

23C. DATE SIGNED: 9-9-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 9-11-49

24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 11 1949

REGISTRAR'S SIGNATURE:

25. FUNERAL DIRECTOR: Jack Lewis Inc.

ADDRESS: 2100 Eutaw Pl

VS 150

36089 Huntington Williams, M.D.

52a

078032 ✓ 078032 ✓

078032 BALTIMORE CITY HEALTH DEPARTMENT 6 ✓ Registered No.

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ABRAHAM DAVIS

2. DATE OF DEATH 9/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL
c. Length of stay in Baltimore √0 Yrs. ~~Mos. Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-05
D. STREET ADDRESS (If rural, give location) 218 No Collington ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married		65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10B. KIND OF BUSINESS OR INDUSTRY House
11. BIRTHPLACE (State or foreign country) Latvia
12. CITIZEN OF WHAT COUNTRY? ✓
13. FATHER'S NAME Moses
14. MOTHER'S MAIDEN NAME Dena
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Herbert Davis ADDRESS 3302 Sumter ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO
(B) Bronchogenic Ca
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASHD

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/1 1949 to 9/8 1949 *that I last saw the deceased alive on* 9/8 1949, *and that death occurred at* 12:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE William Krakower M. D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 9/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9-11-49
24C. NAME OF CEMETERY OR CREMATORY Rosedale
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 11 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis
ADDRESS 2100 Eutaw Pl

VS 150

William Krakower 340 V9 47c

correct age is especially important. A typewriter should be used.

078033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 078033

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Benjamin H. Patterson

2. DATE OF DEATH: September 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Edgewood Nursing Home, 6000 Belliona Avenue

c. Length of stay in Baltimore: 25 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1117 W. 37th Street 13-06

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widower	Aug. 13, 1864	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber	Retired 16 years SEF	Maryland	U S A

13. FATHER'S NAME: Charles Patterson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Mrs. Juha B. Patterson	1117 W. 37th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Arteriosclerosis — 20 years

DUE TO

(C)

ANTECEDENT CAUSES

I DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 1, 1949, to Sept 8th, 1949, *that I last saw the deceased alive on* Sept 8, 1949, *and that death occurred at* 10.10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Arthur J Danes M. D.	800 W 33rd St	9-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 12, 1949	Greenmount	York, Pennsylvania

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 11 1949	Huntington Williams, M.D.	Burgee Funeral Home	3631 Falls Road

760 89

93

078034 BALTIMORE CITY HEALTH DEPARTMENT 078034

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) Harry Ivrey 449918 | 2. DATE OF DEATH SEP 11 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Brady - 4
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Annapolis
D. STREET ADDRESS (If rural, give location) 817 West, Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	married		61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	merchant	?	

13. FATHER'S NAME Abraham Ivrey
14. MOTHER'S MAIDEN NAME Mollie Robinowitz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		JOHNS HOPKINS HOSPITAL	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 19 Mos
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A), STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2/9/48	Benign Prostatic Hyperplasia	YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9 - 9 - 1949 *to* 9 - 11 - , 1949 *that I last saw the deceased alive on* 9 - 11 - , 1949 *and that death occurred at* 3.55 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
William E. Chase M.D.	JOHNS HOPKINS HOSPITAL	9/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 13/49	Kenneth Israel	New annapolis Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 11 1949	Carrington Williams M.D.	B E Hopkins & Bro	annapolis Md.

VS 150

correct age is especially important. Explain any

93D

078035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

078035

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Fite Franklin

2. DATE OF DEATH: Sept. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Sinai Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days: 10 Months

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore 2 Tinker Rd.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Essex Md.
D. STREET ADDRESS (If rural, give location): 2 Tinker Rd. Victory Villa Gardens

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White	Married	Nov. 1, 1848	100	10	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farming	Tennessee	

13. FATHER'S NAME: Lahn Franklin

14. MOTHER'S MAIDEN NAME: Tempie Dixon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No		

17. INFORMANT: Mrs. Tempie Houchen ADDRESS: 2 Tinker Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Embolus - Thrombosis

DUE TO

ANTECEDENT CAUSES

(B) Marked Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Embolus - Rt. Femoral Art; Bronchopn.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 9, 1949, to Sept 10, 1949, *that I last saw the deceased alive on* Sept 10 1949, *and that death occurred at* 9:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jon E. Vanel M. D.	Sinai Hosp.	9/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	9-12-49	Gainsboro	Gainsboro, Tenn.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 11 1949	Huntington Williams, M.D.	Wm. Cook Inc.	1217 St. Paul St.

VS F50

832

BIRTH NO. 078036

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 9 078036

1. NAME OF DECEASED (Type or Print): Ellen Langley

2. DATE OF DEATH: 9-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): President Hospital
c. Length of stay in Baltimore: 15 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1630 Madison Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	Colored	Widowed	May 30, 1918	31		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waitress		Appammatox Va.	U.S.A.

13. FATHER'S NAME: John Thornhill

14. MOTHER'S MAIDEN NAME: Annabelle Cragaway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	218-180-712	Mr Calvin Thornhill	1803 Mc Culloh St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Virus pneumonia — 20 days
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-24-49 19__, *to* 9-9-49 19__, *that I last saw the deceased alive on* 9-9-49, 19__, *and that death occurred at* 1 37 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Lucius M. Sleeper M. D.	President Hosp.	9-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 11, 1949	Mt. Auburn	Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 11 1949	Entry for Will[illegible]	Holland Funeral Home	1631 Druid Hill Ave.

VS 150

109a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 078037 — Registered No. 078037

1. NAME OF DECEASED (Type or Print): Frederick W. Dash

2. DATE OF DEATH: Sept 8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1116 W. Bradford

c. Length of stay in Baltimore: 71 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1116 W. Bradford St 6-03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	March 16/78	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Con Mfg	Maryland	

13. FATHER'S NAME: Frederick Dash

14. MOTHER'S MAIDEN NAME: Anna Richa

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		215-01-6025	Cecelia Dash	1116 W. Bradford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemiplegia — DUE TO

(B) Cerebral Hemorrhage — DUE TO

(C) — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 2 '49 *to* Sept 8 '49, *that I last saw the deceased alive on* Sep 8 '49, *and that death occurred at* 6:46 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
H. Kemp Snyder M. D.	2426 E Biddle	9-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 12/49	Sacred Heart	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 11 1949	Huntington Williams, M.D.	Frank Brockson	

988 3V

83a

078038 ✓ 078038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALMA DAWSON WELLS

2. DATE OF DEATH: Sept. 8th, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 408 East 22nd Street

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: >
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 408 East 22nd Street 12-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	white	single	1873	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Saleslady	Dept Store	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert Wells	Mary D. Dumbarton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	212-01-5868	Miss Jean wells	408 E. 22nd St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) hypertensive Cardiovascular renal disease

DUE TO

(C) diabetes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1941, 19__, *to* Sept 8, 1949 *that I last saw the deceased alive on* July 1, 1949. *and that death occurred at* 10:00 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Jack J. Singer M. D.	506 E. North Ave	9-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/12/49	Woodlawn	City

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 11 1949	Huntington Williams, M.D.	WIEDEFELD AND SON	GREENMOUNT AVE. & 22nd ST.

VS 150 29863

61

078039

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

078039

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LOTTIE M. LANGE

2. DATE OF DEATH 9/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2519 Garrison Blvd
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md 15-38
D. STREET ADDRESS (If rural, give location) 2519 Garrison Blvd

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
F	W	widowed

8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Aug. 4	about 69 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY
clerk	hotel

11. BIRTHPLACE (State or foreign country) Mass.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry J. Lange

14. MOTHER'S MAIDEN NAME Lucie A. Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Lucy L. Frank ADDRESS 2519 Garrison Blvd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic C. V disease	
	DUE TO (B)	
ANTECEDENT CAUSES		
II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑	23C. DATE SIGNED
C. J. Tubenske M.D		9/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/12/49	New Cathedral Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 11 1949		WM. J. TICKNER & SONS	Balto., Md.

937

B.C. 49-18283 CERTIFICATE CORRECTED 2-10-50 078040-40

BIRTH NO. 078040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 76

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Dary Bruce Fischbach | 2. DATE OF DEATH: 9-10-49.

3. PLACE OF DEATH: A. Baltimore City, Maryland: Balto. | B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital. | c. Length of stay in Baltimore: 10 days. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Balto. | B. COUNTY | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. | D. STREET ADDRESS (If rural, give location): 3813 Beech Ave. Balto. 11 - Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months, Days	If Under 24 Hours: Hours, Min.
M.	W.	single	8-31-49.		(9) 10 days	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Md. (Baltimore)	

13. FATHER'S NAME: Mr. Jack T. Fischbach.

14. MOTHER'S MAIDEN NAME: Gloria Jane Belt.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Jack T. Fischbach | ADDRESS: 3813 Beech Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis

DUE TO

(B) Acute Dehydration.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept. 8th, 1949 *to* Sept. 10th, 1949 *that I last saw the deceased alive on* Sept. 10th, 1949, *and that death occurred at* 12:12 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. J. Castellano M. D.	2021 W. Fayette.	Sept. 10th 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/12/49	Druid Ridge Cem.	Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 11 1949	Acting for Registrar	WM. J. TICKNER & SONS	Balto., Md.

VS 150

161a

Q78041

BIRTH NO. B.C. #2981

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 954 Q78041

1. NAME OF DECEASED (Type or Print): Wieneke, Richard Gregory

2. DATE OF DEATH: 9-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 5 hours (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenburnie
D. STREET ADDRESS (If rural, give location): 2 Georgia Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	16 July 1945	4		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Kenwood Alfred Wieneke
14. MOTHER'S MAIDEN NAME: Betty Jane Schmude

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Father — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) anesthetic
DUE TO
(B) surgical shock
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: 9-9-49
19B. MAJOR FINDINGS OF OPERATION: Hyperthyroid T.A. + Redundant Prepuce
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-9 1944 *to* 9-9, 1949 *that I last saw the deceased alive on* 9-9, 1949 *and that death occurred at* 4:30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: J. Robert Haire M.D.
23B. ADDRESS: Junior Hospital
23C. DATE SIGNED: 9-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	SEPT 13, 1949	GLEN HAVEN CEMETERY	ANNE ARUNDEL CO., MARYLAND

DATE RECEIVED BY LOCAL REGISTRAR: SEP 12 1949
REGISTRAR'S SIGNATURE: Penelope Johnson, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: BALTO., MD.

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078042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 78042

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Walter BELT

2. DATE OF DEATH Sept 9 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Catonsville
D. STREET ADDRESS (If rural, give location) 37 Nunnery Lane

4A. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

4B. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
Male	White		Jan 15 1889	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard

10B. KIND OF BUSINESS OR INDUSTRY Eastern Savings Bank

11. BIRTHPLACE (State or foreign country) md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Greenberry Belt

14. MOTHER'S MAIDEN NAME Catherine Hoffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Wilmer A Belt ADDRESS 1529 C35 St Balto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma of

DUE TO

(B) the liver — origin of

DUE TO

(C) CA undetermined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/23 1949 to 9/10, 1949 *that I last saw the deceased alive on* 9/10, 1949 *and that death occurred at* 11:20 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE Hubert J. Lericks M. D.

23B. ADDRESS St. Agnes Hospital

23C. DATE SIGNED 9/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Sept 12 1949

24C. NAME OF CEMETERY OR CREMATORY Glen Haven

24D. LOCATION (City, town, or county) (State) Glen Haven md

DATE RECEIVED BY LOCAL REGISTRAR 9-11-1949

REGISTRAR'S SIGNATURE Everington Williams M.D.

25. FUNERAL DIRECTOR Harry Hutzler ADDRESS 4101 Edmondson ave.

SEP 1 VS 150

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G78043

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 443

G78043

Registered No.

1. NAME OF DECEASED (Type or Print) BENSAMIN MILLER

2. DATE OF DEATH 9-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland SINAI HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL BALTIMORE

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3439 Piedmont Ave 15-38

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor	CLOTHING MFG	Lith.	

13. FATHER'S NAME: Joseph Issackowitz

14. MOTHER'S MAIDEN NAME: Annie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Joseph Miller	3107 Hanlon Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.)
(A) Cerebral Vascular Accident — 6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertensive Arteriosclerotic Cardio vascular disease

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypostatic Bronchopneumonia

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-5, 1949, *to* 9-10, 1949, *that I last saw the deceased alive on* 9-10, 1949, *and that death occurred at* 9⁰⁰ ? m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Arnold H. Michael M. D.	Sinai Hospital Baltimore	9-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 12, 1949	Southern Ave Cemetery	Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 12 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Sol Levinson & Bros — ADDRESS 1126 W North Ave

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43D

078044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. 078044

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD C. KROLL

2. DATE OF DEATH Sept. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3406 Hayward Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3406 Hayward Ave. 2-7-16

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	Sept. 12, 1890	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tinner (Tinsmith)	Self	Baltimore, Md.	

13. FATHER'S NAME: Samuel E. Kroll

14. MOTHER'S MAIDEN NAME: Anna M. Ludolf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
No		Mrs Charlotte J. Kroll, 3406 Hayward Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
DUE TO
(B) generalized arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐, NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-24, 1943 *to* 9-9, 1949, *that I last saw the deceased alive on* 9-9, 1949 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE Harry L. Kimball M. D. | 23B. ADDRESS 2203 Edmondson Ave | 23C. DATE SIGNED 9-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/12/49	Meadow Ridge Memorial	Dorsey, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 12 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 150

83a

078045

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

078045

Registered No.

1. NAME OF DECEASED (Type or Print) ELIZABETH GERTA WEHRLE

2. DATE OF DEATH Sept. 9, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 101 S. Augusta Ave.

C. Length of stay in Baltimore 63 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 101 S. Augusta Ave. 20-08

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) last birthday	If Under 1 Year Months	Days	If Under 24 Hours Hours	Min.
Female	White	Married	Jan. 8, 1884	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Saxon, Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Albert Oelman

14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT ADDRESS William Wehrle, 101 S. Augusta Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular disease — 6 years

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1946, *to* Sept. 9, 1949, *that I last saw the deceased alive on* Sept. 9, 1949, *and that death occurred at* 8:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leonard Yaffe M. D.	310 W Baltimore St.	9/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/13/49	Parkwood	Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
SEP 12 1949	Huntington Williams, M.D.	William Cook, Inc., 1217 St. Paul St.

VS 150

93D

AB-131323
078046
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4210 078046 Registered No.

1. NAME OF DECEASED (Type or Print): Louise Hartman
2. DATE OF DEATH: 9-9-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 732 Lennox St. 13-0 N

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months, Days	If under 24 hours: Hours, Min.
FEMALE	White	Widowed	Jan. 9- 1872	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME: James Ruhland (D
14. MOTHER'S MAIDEN NAME: Katrina ? (D

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	16. (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
			Baltimore City Hospitals Records: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebrovascular accident due to arteriosclerotic Heart disease
DUE TO
(B) Diabetes Mellitus
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 8-25- , 1949 *to* 9-9- , 1949 *that I last saw the deceased alive on* 9-9- , 1949 *and that death occurred at* 10.30 PM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. S. Bozer M. D.	Baltimore City Hospitals	9-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/13/49	Lorraine	Hyattsville Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 12 1949	Huntington Williams, M.D.	Wm Cook Inc	1217 E Baltimore St

VS 150

61

FeFeL

G78047

BALTIMORE CITY HEALTH DEPARTMENT 1949

CERTIFICATE OF DEATH

Registered No. G78047

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr. John O. Fefel

2. DATE OF DEATH: 9-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 20-03
D. STREET ADDRESS (If rural, give location): 2015 Ramsay St. - Balto. 23. Md.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Widowed	3-9-73	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Produce Man.	Self	Md.	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Barbara Zell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
			Mary E. Hauf 132 Cherry Dell Rd Catonsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Cardiac Failure. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Carcinoma. (over)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 7, 1949 *to* Sept. 10, 1949, *that I last saw the deceased alive on* Sept. 10, 1949, *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
O. J. Cattlaw M. D.	2025 W. Fayette	9-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/13/49	New Cathedral	Balto Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR
SEP 12 1949	Huntington Williams, M.D.	Pott & B. M. Walter Pratt Stuckyak

VS 150

156 61

55E

078048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

175

078048 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MRS. MARY HAFFER

2. DATE OF DEATH 9-12-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL

c. Length of stay in Baltimore LIFE. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALT.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 25-43
D. STREET ADDRESS (If rural, give location) 1722 SPENCE ST. # 30.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
FEMALE	WHITE.	MARRIED	10 FEB. 1909	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE.		BALTIMORE, MD.	U.S.

13. FATHER'S NAME RALPH HIGDON

14. MOTHER'S MAIDEN NAME ESTELLE DAVIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) GENERALIZED ABDOMINAL CARCINOMATOSIS
DUE TO
(B) PAPILLARY CYSTADENOCARCINOMA OVARY 1 YR.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 MO.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-11-, 19 4, *to* 9-12, 19 49 *that I last saw the deceased alive on* 9-12-, 19 49 *and that death occurred at* 12:45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Douglas Kerr M. D.	Maryland General Hospital	9-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-15-49	Loudon Park	Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 12 1949	Huntington Williams, M.D.	Edward Loudon	2359 Wash. Blvd.

VS 150

49a

078049

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 v

078049

Registered No.

1. NAME OF DECEASED (Type or Print) Amelia Virginia Preston

2. DATE OF DEATH Sept. 14 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) #100 Edgevale Ave - 10-

c. Length of stay in Baltimore 87 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28 v
D. STREET ADDRESS (If rural, give location) 5202 Fernpark Avenue -7-

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	Dec. 11, 1862	86 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William F. Stump, Sr.

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) –
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. –

17. INFORMANT: Mr. Ernest O. Preston ADDRESS: 5202 Fernpark Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-vascular-renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO

(B) Arteriosclerotic Cardiovascular Disease — 20 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 30 1949 *to* Sept. 9, 1949 *that I last saw the deceased alive on* Sept 9, 1949 *and that death occurred at* 6 3/4 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Millard T. Trabold M. D.

23B. ADDRESS: 3700 Woodbine Ave. -7-

23C. DATE SIGNED: 9/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 9/13/49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 12 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

1310

78050 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 078030

1. NAME OF DECEASED (Type or Print) MARY BROOKS

2. DATE OF DEATH September 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 810 Whatcoat Street

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
female	colored	Widow	3-17-1896	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Virginia	U.S

13. FATHER'S NAME Charles Gordon

14. MOTHER'S MAIDEN NAME Mary —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		None	Anderson Brooks	813 Whatcoat St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the ovaries with metastasis
DUE TO
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

1 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR	23C. DATE SIGNED
H. J. McClafferty M.D.		Sept. 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/12/49	Mt Calvary	A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 12 1949	Huntington Williams, M.D.	Cayner Sanders	1412 E. Preston St

VS 151

49a

078051

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 078051

1. NAME OF DECEASED (Type or Print): Jane E. Hartsock

2. DATE OF DEATH: 9-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto Gen Hosp

c. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 2917 W. Lanvale St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 16.06
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	W	S	11/27/27	21	8 / 19	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Lady

10B. KIND OF BUSINESS OR INDUSTRY: Stewart & Co.

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles D. Hartsock

14. MOTHER'S MAIDEN NAME: Mae Stevenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-22-4238

17. INFORMANT: Charles D. Hartsock
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hodgkin's disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yr

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-2 19 49 *to* 9-10 19 49 *that I last saw the deceased alive on* 9-10 19 49 *and that death occurred at* 12 15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Joseph Shear M. D.	West Balto Gen Hosp	9-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	9/13/49	McKendree	Near Cooksville, Howard Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 12 1949	Huntington Williams, M.D.	Charles C. Towell	3437 Edmondson Ave

VS 150

298 63

44B

AB-93082

078052

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331

078052

Registered No.

1. NAME OF DECEASED (Type or Print) Elizabeth Grandison

2. DATE OF DEATH 9-10-1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore 44yrs (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 1701 Madison Ave. 14-07

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	Negro	Separated	?-?-1874?	75?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Virginia	

13. FATHER'S NAME: Mack Lucas

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4-12- , 1945 *to* 9-10- , 1949 *that I last saw the deceased alive on* 9-10- , 1949 *and that death occurred at* 11.45 PM *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
C. S. Cozen M. D.	Baltimore City Hospitals	9-11-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-15-1949	Mt. Auburn	Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 12 1949	Huntington Williams, M.D.	Holland Funeral Home	1801 Druid Hill Ave

VS 150

832

078053

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 078053

1. NAME OF DECEASED (Type or Print) Rickards, Robert William

2. DATE OF DEATH Sept. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S. Marine Hospital

c. Length of stay in Baltimore unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New Jersey B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Absecon

D. STREET ADDRESS (If rural, give location) 35 Bolton Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	single	July 21, 1893	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Seafarer		New Jersey	US

13. FATHER'S NAME Robert Rickards

14. MOTHER'S MAIDEN NAME Lida Betts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
unkn	unkn	Records U.S. Marine Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
(A)	Bronchogenic carcinoma arisin in left upper lobe main stem bronchas	Unkn
DUE TO (B)	Metastases to mediastinal, periaortic axillary, and retroperitoneal lymph nodes and to liver.	Unkn.
DUE TO (C)		

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus — Unkn.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
June 16, 1949	Diagnosis as above	YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 20, 1949 *to* Sept. 10, 1949, *that I last saw the deceased alive on* Sept. 10, 1949, *and that death occurred at* 6.30P *m., from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
James O. Davis M. D.	U.S. Marine Hosp.	9/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 13, 1949	Roxanna	Roxanna, Delaware

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
SEP 12 1949	Huntington Williams, MD	Howard H. Hubbard, 2503 Edmondson Ave

VS 150

47c

(978054) BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46

(978054) Registered No.

1. NAME OF DECEASED (Type or Print): HARRY B. COHEN

2. DATE OF DEATH: 9-12-49

3. PLACE OF DEATH: a. Baltimore City, Maryland — Mery Hosp

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): mercy Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days: 3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New York
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 326 Vincent Ave, Lynbrook, L.I.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan 14 1893
9. AGE (In years last birthday): 56 — Under 1 Year: Months / Days; Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): architect
10B. KIND OF BUSINESS OR INDUSTRY: ?
11. BIRTHPLACE (State or foreign country): Penn
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Isadore Cohen
14. MOTHER'S MAIDEN NAME: Besay Cohn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ✓
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hattye Cohen — ADDRESS: 359 Vincent Ave Lynbrook L.I.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) peritonitis
DUE TO
(B) mesenteric thrombosis?
DUE TO
(C) diabetes mellitus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 8, 19 49 *to* Sept 12, 19 49, *that I last saw the deceased alive on* Sept 12, 1949, *and that death occurred at* 1:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Burton V Lock M.D.
23B. ADDRESS: Mercy Hosp
23C. DATE SIGNED: 9-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: Sept 12/49
24C. NAME OF CEMETERY OR CREMATORY: ?
24D. LOCATION (City, town, or county) (State): New York City

DATE RECEIVED BY LOCAL REGISTRAR: SEP 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1124-26 W North Avenue

VS 150

611

AB-131672
78055

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 49-19558

CERTIFICATE OF DEATH

Registered No. 078055

1. NAME OF DECEASED (Type or Print): Baby Boy Lake

2. DATE OF DEATH: 9-10-1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 1409 Raleigh Way

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Single	Sept. 7-1949			3

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Quenton Lake
14. MOTHER'S MAIDEN NAME: Ruth Beck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Baltimore City Hospitals Records: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Erythroblastosis Fetalis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [ ] NO [X]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-7- , 1949, *to* 9-10- , 1949 *that I last saw the deceased alive on* 9-10- , 1949, *and that death occurred at* 8A *m., from the causes and on the date stated above.*

23A. SIGNATURE: E. S. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 9-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)
Burial.	Sept 13 1949	Mt. Carmel.	Odonell St.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Randall J. Hoppe ADDRESS: 312 S. Highland ave

VS 150

161c

078056

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

078056

Registered No.

1. NAME OF DECEASED (Type or Print) Betty Stanley

2. DATE OF DEATH 9-12-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1517 Ashland Av

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 3 Yrs. ~~Mos. Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md.
D. STREET ADDRESS (If rural, give location) 1517 Ashland Av

5. SEX	6. COLOR OR RACE	7. SINGLE, ~~MARRIED, WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	SINGLE	11.25.28	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Airlys Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Carell Stanley
14. MOTHER'S MAIDEN NAME Mamie Mortimer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Alveda Parker ADDRESS 1517 Ashland Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: UNK
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6.9 *, 19*49 *to* 9.12 *, 19*49 *that I last saw the deceased alive on* 9.11 *, 19*49 *and that death occurred at* 6.30 *m., from the causes and on the date stated above.*

23A. SIGNATURE RAYNER BROWNE, M.D. 150 EAST MADISON ST. BALTIMORE 2, MD.
23B. ADDRESS 1500 E Mad St
23C. DATE SIGNED 9-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 14, 1949		Airlys Rochester Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 12 1949
REGISTRAR'S SIGNATURE: Turnington for Nathanson, M.D.
25. FUNERAL DIRECTOR: Elroy O Wilson ADDRESS: 1000 Brentley Ave

VS 150

138

AB.-131503

778057

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 778057

1. NAME OF DECEASED (Type or Print): William Dorsey

2. DATE OF DEATH: 9-7-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2220 N. Howard St.

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 10- 1869
9. AGE (In years last birthday): 80 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Isaac Dorsey
14. MOTHER'S MAIDEN NAME: Henrietta Rice
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S ADDRESS: Baltimore City Hospitals Records: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia
DUE TO
(B) Uremia
DUE TO
(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: 8-31-1949
19B. MAJOR FINDINGS OF OPERATION: Exploratory Laparotomy for Intestinal Obstruction
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-31- , 19 49 *to* 9-7- , 19 49 *that I last saw the deceased alive on* 9-7- 19 49 *and that death occurred at* 9.08 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: C. L. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 9-8-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-13-49
24C. NAME OF CEMETERY OR CREMATORY: MT. ALBURN Cemetery
24D. LOCATION (City, town, or county) (State): A.A.Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William A. Jackson
ADDRESS: 916 Penna Ave.

VS 150

108

978058

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 978058

1. NAME OF DECEASED (Type or Print): Sister Mary Gerard (Finnegan) O.S.F.

2. DATE OF DEATH: Sept. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3725 Ellerslie Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Elizabeth's Home 3725 Ellerslie Avenue

c. Length of stay in Baltimore: Since 1926 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE [redacted] MD.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 9-01 As ~~above~~ 3725 Ellerslie Ave.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	White	Single	April 11, 1883	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teaching ---but not for 24 years due to illness

10B. KIND OF BUSINESS OR INDUSTRY: ORPHAN HOME

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? Ireland

13. FATHER'S NAME: Jeremiah Finnegan

14. MOTHER'S MAIDEN NAME: Mary(Finnegan)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Rheumatoid Arthritis, severe, generalized, complete ankylosis all joints. — 24 yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1946, *to* 11 Sept., 1949 *that I last saw the deceased alive on* 9 Sept., 1949, *and that death occurred at* 6.30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wm. H. Kammer, Jr. M. D.	501 Sheridan Ave.	12 Sept. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	9-13-1949	ST. ELIZABETH'S HOME	BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 12 1949	Huntington Williams, M.D.	H.W. JENKINS & SONS CO.	4905 YORK RD.

VS 150

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107

078059 4. BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 78 078059 Registered No.

1. NAME OF DECEASED (Type or Print): WALTER JONES — N-9674

2. DATE OF DEATH: September 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1021 Linden Avenue 11-54

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 4/2/17
9. AGE (In years last birthday): 32 — If under 1 year: Months, Days; If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker
10B. KIND OF BUSINESS OR INDUSTRY: Saloon
11. BIRTHPLACE (State or foreign country): Essex Co., Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Willie E. Jones
14. MOTHER'S MAIDEN NAME: Ida Schools
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 218-14-5878
17. INFORMANT: Bernice Jones — ADDRESS: 1021 Linden Ave-1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gunshot wounds of
DUE TO Abdomen, right thigh
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.): Friends home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 923 Linden Avenue
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: September 4, 1949 Approx. 11 a.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? (Firearms): Shot during altercation

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/13/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: SEP 12 1949
REGISTRAR'S SIGNATURE: Huntington Baltimore, Md.
25. FUNERAL DIRECTOR — ADDRESS: Charles R. Law-802 Madison Ave--1

VS 151

166

AB-106219

78060
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G78060
Registered No.

1. NAME OF DECEASED (Type or Print): Thomas Cavanaugh

2. DATE OF DEATH: 9-10-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 42yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1441 Williams St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	White	Single	Aug. 22-1889	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Arthur Cavanaugh (D
14. MOTHER'S MAIDEN NAME: Catherine Murthay
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals Records: ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ~~XXXX~~ DUE TO: Pulmonary Tuberculosis
Carcinoma of Lung.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO:
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [Yes] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-19, 1946 *to* 9-10-, 1949, *that I last saw the deceased alive on* 9-10-, 1949 *and that death occurred at* 2 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 9-10-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/13/1949	Cathedral Cemetery	Baltimore - Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Flynn & Fleming 1426 Light Street.

VS 150

47

8061 — 078061

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MARY C. MEEHAN

2. DATE OF DEATH: Sept. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Greenway Apts 34th and Charles Sts.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Greenway Apts, 34th & Charles Sts.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	Widowed	About 70			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore, Md.	

13. FATHER'S NAME: Not obtainable

14. MOTHER'S MAIDEN NAME: Not obtainable

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
		Mrs. Victor B. Mackey 6302 Bellona ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — Interval between onset and death: 1 yr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Thrombosis — 1 yr

DUE TO

(C) arteriosclerosis — ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/23/49, 19__, *to* 9/10/49, 19__, *that I last saw the deceased alive on* 9/9/49, 19__, *and that death occurred at* 2:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Francis W. Gluck M. D.	3406 St Paul St	9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/13/49	Cathedral Cemetery	Baltimore, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR / ADDRESS
SEP 13 1949	Huntington Williams, M.D.	H. H. Mears and Son - 805 N. Calvert St.

VS 150

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78062 X ✓ G78062

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

178 Registered No.

1. NAME OF DECEASED (Type or Print): EDWIN SMITH

2. DATE OF DEATH: Sept. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: 45 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Somerset
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Princess Ann
D. STREET ADDRESS (If rural, give location): Pine Beach Rt. #2

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Married	6/5/04	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Captain
10B. KIND OF BUSINESS OR INDUSTRY: Seafarer
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Wm. John Smith
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: 090-14-2874
17. INFORMANT: Records- US Marine Hospital, Balto, Md. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of The Testicle with Generalized metastasis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: —

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 29, 1949, *to* Sept. 12, 1949 *that I last saw the deceased alive on* Sept. 12, 1949, *and that death occurred at* 5:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John F. Fonnieg M. D.
23B. ADDRESS: US Marine Hospital, Balto. Md.
23C. DATE SIGNED: 9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 14 1949
24C. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
24D. LOCATION (City, town, or county) (State): Mt Vernon, Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR (ADDRESS): Dale Dashiell Princess Anne, Md.

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78063

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G78063
Registered No.

1. NAME OF DECEASED (Type or Print): ROBERT FULTON TILGHMAN

2. DATE OF DEATH: 9-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
c. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3603 REISTERSTOWN RD.

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: JAN 16, 1873
9. AGE (In years last birthday): 76 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAINTENANCE WORK
10B. KIND OF BUSINESS OR INDUSTRY: NATIONAL CAN CO.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: WILLIAM H. TILGHMAN
14. MOTHER'S MAIDEN NAME: MARY POWELL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): UNKNOWN (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: PATIENT — ADDRESS: SEE ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) ARTERIOSCLEROTIC HEART DISEASE — 7
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-11, 1949 *to* 9-12, 1949, *that I last saw the deceased alive on* 9-12, 1949, *and that death occurred at* 9 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Richard R. Beach, M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 9/15/49
24C. NAME OF CEMETERY or CREMATORY: Middleburg
24D. LOCATION (City, town, or county) (State): Va

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. — ADDRESS: 1217 St. Paul St.

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780c4

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G780c4

Registered No.

1. NAME OF DECEASED (Type or Print) William R. Stevens

2. DATE OF DEATH 11 Sept 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 26-9

D. STREET ADDRESS (If rural, give location) 3522 O'Donnell St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
M	W	Married

8. DATE OF BIRTH 7/23/1900

9. AGE (In years last birthday) 49 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator

10B. KIND OF BUSINESS OR INDUSTRY Canton R.R

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Zill Stevens

14. MOTHER'S MAIDEN NAME Lucille Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Loretta M. Stevens ADDRESS 3 N. Broadway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Renal Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

II
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Tbc of Kidneys bilateral — ?

DUE TO

(C) Tbc of Lungs - bilateral — ?

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Tbc Enteritis, Tbc Prostatitis, Tbc peritonitis — ?

19A. DATE OF OPERATION None

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) None

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] —

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 16 Aug, 1949, *to* 11 Sept, 1949, *that I last saw the deceased alive on* 11 Sept, 1949, *and that death occurred at* 4:45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE Henry Schadt M. D.

23B. ADDRESS Sinai Hospital

23C. DATE SIGNED 11 Sept 49

24A. BURIAL, ~~CREMATION, REMOVAL (Specify)~~ Burial

24B. DATE 9/14/49

24C. NAME OF CEMETERY OR CREMATORY Oak Lawn

24D. LOCATION (City, town, or county) (State) Eastern Ave. Extended

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 127 St. Paul St.

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780n5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G780n5 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Thomas J. Huggins

2. DATE OF DEATH 9/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3103 Glenmore Ave
C. Length of stay in Baltimore Yrs. Mos. Days 27 44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 3103 Glenmore Ave

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	White	Married	11/17/1866	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Proprietor	Hardware Store	Balto Md.	

13. FATHER'S NAME Thomas Julius Huggins

14. MOTHER'S MAIDEN NAME Jane Magraw — 3103 Glenmore Ave

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Mary M. Huggins	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Acc. Hemorrhage

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B) Arteriosclerotic C.V.D.
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 72-96 hrs.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 6, 1949, *to* Sept. 10, 1949, *that I last saw the deceased alive on* Sept. 10, 1949, *and that death occurred at* 3:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	4118 Harford Rd.	9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/13/49	West Nottingham	Rising Sun Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 13 1949	Huntington Williams, M.D.	Wm. Cook Inc.	1217 St. Paul St.

VS 150

156 72

937

8066

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G78066

1. NAME OF DECEASED (Type or Print): George A Watkins

2. DATE OF DEATH: Sept 11. 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2036 Ellsworth St

c. Length of stay in Baltimore: Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 2036 Ellsworth St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: Dec 23, 1882
9. AGE (In years last birthday): 67
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gas Fitter
10b. KIND OF BUSINESS OR INDUSTRY: Gas & Electric
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel R Watkins
14. MOTHER'S MAIDEN NAME: Anna Gashey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Anna Greenbock ADDRESS: 2036 Ellsworth

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchogenic Carcinoma — Interval between onset and death: 6 mo.
DUE TO
(B) Hypertension — year.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1947 to 9-11, 1949 that I last saw the deceased alive on 9-10, 1949 and that death occurred at 7A m., from the causes and on the date stated above.

23a. SIGNATURE: William L. Penny M. D.
23b. ADDRESS: 3025 Belair Road
23c. DATE SIGNED: 9-12-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/14/49
24c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24d. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 1949
REGISTRAR'S SIGNATURE: Huntington Pollitt, M.D.
25. FUNERAL DIRECTOR: Wilhorn & Doe
ADDRESS: 1214 Eutaw St

VS 150

FEARING

47c

80667

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G78067

BIRTH NO :

1. NAME OF DECEASED (Type or Print) HERBERT T. BAILEY

2. DATE OF DEATH 9-10-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 688 Pierce St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 1 - Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 688 Pierce St. 17-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
M	C	CHILD	6-5-48	3				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		ACCOMAC - Co. VA.	U. S. A.

13. FATHER'S NAME John T. Bailey

14. MOTHER'S MAIDEN NAME Addie Mae Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.

17. INFORMANT Ella Bailey ADDRESS 688 Pierce St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diarrhea

DUE TO

(B) Malnutrition

DUE TO

(C) Malnourished

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 days

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/4 '49 *to* 9/10 '49 *that I last saw the deceased alive on* 9/9 '49 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE	M. D.	23B. ADDRESS	23C. DATE SIGNED
[illegible] Garner		2-52 Cathedral St.	9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-13-49	Mt. Auburn Cemetery	A.A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 1949

REGISTRAR'S SIGNATURE [redacted]

25. FUNERAL DIRECTOR: William H. Jackson ADDRESS: 916 Penna Ave.

VS 150.

120a

78068 G78068

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): THOMAS DUFF
2. DATE OF DEATH: Sept. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL
c. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 13-08
D. STREET ADDRESS (If rural, give location): 3542 BUENA VISTA AVE.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
MALE	WHITE	SINGLE	JUNE 14, 1928	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
STUDENT		MARYLAND.	

13. FATHER'S NAME: JESSE L. DUFF
14. MOTHER'S MAIDEN NAME: MARGARET H. GEISBERT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
✓	✓	

17. INFORMANT: JESSE L. DUFF - ADDRESS: 3542 BUENA VISTA AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CHRONIC MYELOID LEUKEMIA — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs.
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 15, 1949, *to* Sept 12, 1949, *that I last saw the deceased alive on* Sept 12, 1949, *and that death occurred at* 1:40 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Leon E. Kaser M. D.	Sinai Hospital	9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 15/49	Mt. Olive	Randallstown, Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 13 1949	Huntington Williams, M.D.	Eustace E. Donovan	3615 Poland Ave

VS 150

74a

~~78068~~ G78068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G78068

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bluma Sneider

2. DATE OF DEATH: 9-12-49

3. PLACE OF DEATH: A. Baltimore City, Maryland; B. FULL NAME OF HOSPITAL OR INSTITUTION: Mt Sinai Home; (If not in hospital or institution, give street address or location) 4613 Park Heights

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6 or; D. STREET ADDRESS (If rural, give location) 110 No Lakewood Ave

c. Length of stay in Baltimore: 45 Yrs. Mos. Days

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH

9. AGE (In years last birthday): 98 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Russ

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Louis Harris ADDRESS: 110 No Lakewood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Renal disease — INTERVAL BETWEEN ONSET AND DEATH: 4 months

DUE TO

(B) Generalized arteriosclerosis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 3 1949 *to* aug 24, 1949 *that I last saw the deceased alive on* aug 26 1949 *and that death occurred at* — m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. J. Sanker M. D.

23B. ADDRESS: 100 N. Mulberry

23C. DATE SIGNED: 9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 9-13-49

24C. NAME OF CEMETERY OR CREMATORY: Beth Tfiloh

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

937

78020

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G78070

Registered No.

1. NAME OF DECEASED (Type or Print) CHARLES FLITMAN

2. DATE OF DEATH 9-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL of BALTIMORE

c. Length of stay in Baltimore 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12
D. STREET ADDRESS (If rural, give location) 1829 No Charles St

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER

8. DATE OF BIRTH

9. AGE (In years last birthday) 58 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Owner

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Shar

14. MOTHER'S MAIDEN NAME Simia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Jean Shevitz-3212 Dudeith Ave ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ABDOMINAL CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH 4 mos

DUE TO

(B) CARCINOMA of PANCREAS ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-7 *, 19*49 *to* 9-12 *, 19*49 *that I last saw the deceased alive on* 9-12 *, 19*49 *, and that death occurred at* 5.40 p *m., from the causes and on the date stated above.*

23A. SIGNATURE Ronald H. Michael M. D.

23B. ADDRESS SINAI HOSPITAL of BALTIMORE

23C. DATE SIGNED 9-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9-13-49

24C. NAME OF CEMETERY OR CREMATORY Hebrew Mt Carmel

24D. LOCATION (City, town, or county) (State) Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Lewis Inc

ADDRESS 2100 Eutaw Pl

VS 150

156 F7.

469

78071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G78071 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NATHAN AZRILANT

2. DATE OF DEATH 9-12-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Levindale

C. Length of stay in Baltimore 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3-0 W
D. STREET ADDRESS (If rural, give location) 1004 E Lombard St

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH
9. AGE (In years) 88 If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chicken Dealer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Abraham
14. MOTHER'S MAIDEN NAME Rose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT R. Dubin ADDRESS 1011 E Lombard St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of pancreas — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. General arteriosclerosis

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-25, 1943, to 9-12, 1949 that I last saw the deceased alive on 9-12, 1949, and that death occurred at 1:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE Henry Nagel, M. D.
23B. ADDRESS Levindale Home
23C. DATE SIGNED 9-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9-13-49
24C. NAME OF CEMETERY OR CREMATORY Rozedale
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eutaw Pl

VS 150

469

B-120273

8072
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

500 G78072
Registered No.

1. NAME OF DECEASED (Type or Print) Clarence Johnson

2. DATE OF DEATH 9-12-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore — Yrs. Life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 1848 N. Chester St. 8-05

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct. 18- 1889
9. AGE (In years last birthday) 59 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stage hand & painter,
10B. KIND OF BUSINESS OR INDUSTRY Town Theatre
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Johnson
14. MOTHER'S MAIDEN NAME Mary E. Owens
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-01-0296
17. INFORMANT'S ADDRESS Baltimore City Hospitals Records: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arterio--Sclerosis, Generalized
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hemiplegia, right

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-8- , 1948 *to* 9-12- , 1949, *that I last saw the deceased alive on* 9-12- , 1949, *and that death occurred at* 10.15AM, *from the causes and on the date stated above.*

23A. SIGNATURE R. L. Rogers M. D.
23B. ADDRESS Baltimore City Hospitals
23C. DATE SIGNED 9-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial
24B. DATE 9/15/49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.
BALTIMORE - 13, MARYLAND

VS 150

83 D

8073

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

561.0

G78073

Registered No.

1. NAME OF DECEASED (Type or Print) Edward S. King

2. DATE OF DEATH 9-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital
C. Length of stay in Baltimore 40 yr (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17
D. STREET ADDRESS (If rural, give location) 700 W. North Ave 13 or

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	M.	Jan 13 - 1891	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Grocery Clerk	Dept. Store	Maryland (Balto.)	USA

13. FATHER'S NAME Emerson King

14. MOTHER'S MAIDEN NAME Catherine Schaugnessy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	161-12-6873	Mrs. Ruth C. King	700 W. North Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Pulmonary embolus, left	30 min.
DUE TO (B)	Thrombophlebitis pampiniform plexus & left inguinal region	14 da.
(C)	Incarcerated inguinal hernia	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-25-49	Incarcerated Inguinal Hernia	YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-21-49 19__; *to* 9-11-49, 19__, *that I last saw the deceased alive on* Sept 11, 1949, *and that death occurred at* 11:45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Wayne N. Jacobus MD M. D.	Church Home Hosp.	12 Sept 49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/14/49	Mt. Olivet Cemetery	Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 13 1949	Huntington Williams, M.D.	WM. J. TICKNER & SONS	Balto., Md.

VS-150

1220

G78074

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G78074

1. NAME OF DECEASED (Type or Print). Norman Rogers Keeling

2. DATE OF DEATH 9/12/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Mercy Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12th
D. STREET ADDRESS (If rural, give location) 201 E. University Pkwy.

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Oct. 31, 1876 | 9. AGE (In years last birthday) 72 | If Under 1 Year: Months 10, Days 12 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Rail Road | 10B. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Keeling

14. MOTHER'S MAIDEN NAME Eliza W. Stubbs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Dora E. Keeling ADDRESS 201 E. University Pkwy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
(B) Coronary Thrombosis — 2 weeks
DUE TO
(C) Arterio-Sclerosis, Generalized

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/20, 1949, *to* 9/12, 1949, *that I last saw the deceased alive on* 9/12, 1949, *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Thomas B. Turner M. D. | 23B. ADDRESS Mercy Hospital | 23C. DATE SIGNED 9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/14/49 | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Wm. J. TICKNER & SONS | ADDRESS Balto., Md.

VS 150

94a

8075

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 078075

1. NAME OF DECEASED (Type or Print): CHARLES H. HOOTON

2. DATE OF DEATH: Sept. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3200 Elgin Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3200 Elgin Ave. 9-5-47

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widower
8. DATE OF BIRTH: Apr. 20, 1853
9. AGE (In years last birthday): 96 yrs.
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none RAILWAY MAIL CLERK
10B. KIND OF BUSINESS OR INDUSTRY: U.S.
11. BIRTHPLACE (State or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert L. Hooton
14. MOTHER'S MAIDEN NAME: Mary Felton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Miss Claire L. Hooton ADDRESS: 3200 Elgin Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) UREMIA
DUE TO
(B) ARTERIOSCLEROTIC CVHD
DUE TO
(C) GENERALIZED ARTERIOSCLEROSIS
SENILITY

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 6, 1949, *to* Sept 12, 1949 *that I last saw the deceased alive on* Sept 12, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Willard Appenzellar M. D.
23B. ADDRESS: 2511 Reisterstown Rd
23C. DATE SIGNED: 9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/15/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 19 49
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

25495

93D

v. Zimmerman
2838 Hayford
8076

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G78076

1. NAME OF DECEASED (Type or Print) Mary Ann Bremner — 2. DATE OF DEATH Sept. 12-1949

3. PLACE OF DEATH: a. Baltimore City, Maryland — 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3401 Lake Montebello Dr. — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-07

c. Length of stay in Baltimore: Yrs. 6 Mos. Days — D. STREET ADDRESS (If rural, give location) 3401 Lake Montebello Drive

5. SEX female — 6. COLOR OR RACE White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed — 8. DATE OF BIRTH Nov. 9-1871 — 9. AGE (In years last birthday) 77 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home — 10B. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) W. Virginia — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Hopkins — 14. MOTHER'S MAIDEN NAME Margaret Montebello

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Margaret Bremner-3401 Lake

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 mo

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 10, 1949 to Sept 12, 1949 that I last saw the deceased alive on Sept 11, 1949, and that death occurred at A m., from the causes and on the date stated above.

23A. SIGNATURE Fred Zimmerman M. D. — 23B. ADDRESS 2838 Hayford Rd — 23C. DATE SIGNED 9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE 9-15-49 — 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer — 24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949 — REGISTRAR'S SIGNATURE Transcription from Baltimore, Md. — 25. FUNERAL DIRECTOR Leonard J. Luck — ADDRESS 5305 Harford

VS 150

93E

80??

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

53

G78077

Registered No.

1. NAME OF DECEASED (Type or Print) Gross, Bessie

2. DATE OF DEATH 9/8/49 47

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 618 Hawser St. 22-2

5. SEX Female
6. COLOR OR RACE Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Aug. 1, 1898
9. AGE (In years last birthday) 51
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frank Stanley

14. MOTHER'S MAIDEN NAME Mary OFfor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, war or unknown) No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT William Gross ADDRESS 618 Hawser St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fecal Peritonitis — INTERVAL BETWEEN ONSET AND DEATH 28 days
DUE TO
(B) Mishelig Resection
DUE TO
(C) Carcinoma of Trans. Colon

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 8/19/49
19B. MAJOR FINDINGS OF OPERATION Ca Transverse Colon
20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/13, 19 49, *to* 9/8, 19 49, *that I last saw the deceased alive on* 9/8/49, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS University Hospital
23C. DATE SIGNED 9/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept. 14, 1949
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Am. Cedar Hill Md.
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949
REGISTRAR'S SIGNATURE [signature] Registrar of Baltimore, Md.
25. FUNERAL DIRECTOR Mrs Katie B Williams ADDRESS 522 Lakewood Ave

VS 150

46E

78078

BIRTH NO. M-4320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G78078 Registered No.

1. NAME OF DECEASED (Type or Print) RONALD MURPHY

2. DATE OF DEATH September 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 114 N. Fremont Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hours: Hours	Min.
male	colored	----	March 1946	3				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----
10B. KIND OF BUSINESS OR INDUSTRY ----
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Murphy, born, Griffton, N.C.
14. MOTHER'S MAIDEN NAME Rheta Murphy, born -- Brooklyn, Md.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT James Murphy ADDRESS 114 N. Fremont Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Malnutrition
DUE TO Mental retardation
Kernicterus (icterus hymolytic of the newborn)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE R. S. Fisher M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED Sept. 10, '49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept. 13 1949
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.
24D. LOCATION (City, town, or county) (State) Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949
REGISTRAR'S SIGNATURE Certified from Baltimore, Md.
25. FUNERAL DIRECTOR Mrs Kate P. Williams
ADDRESS 522 N. Lakewood Ave

VS 151

737

78079

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G78079

Registered No.

1. NAME OF DECEASED (Type or Print) Carrie Williams.

2. DATE OF DEATH 9-9-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1711 Idalen Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1711 Idalen Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore, Md.
D. STREET ADDRESS (If rural, give location) 1711 Idalen Ave. 16 03

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	C	Widow	July 30 1878	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Fredericks Md.	

13. FATHER'S NAME: Carrol Littles.

14. MOTHER'S MAIDEN NAME: Eliza Jones.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mr. Clarence Williams	1711 Idalen Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr. Endocarditis
DUE TO
(B) & Myocarditis & Gen. Arteriosclerosis
DUE TO
(C) Malnutrition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from July, 1949, to Sept 9, 1949, that I last saw the deceased alive on 9/9/1949 and that death occurred at 5:05 p.m., from the causes and on the date stated above.

23. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Walter S. Taylor M. D.	1522 Harlem Ave	9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept. 13 1949	Mt. Auburn Cem	Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 13 1949	Hunter for Williams, M.D.	Mrs Katie R Williams	N. Johnson

VS 150

92D

8080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G78080 Registered No.

IRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES J. SLAMA, Sr.

2. DATE OF DEATH Sept. 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3314 Elmley Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3314 Elmley Avenue

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	married	Dec. 23, 1894	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shoemaker	-	Baltimore, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Slama	Anna Kutrnik

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	U.S.Army	212-12-4673	Mrs. Marguerite Slama,	3314 Elmley Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH 3/4 hr.
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Moderate Arteriosclerosis
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Congenital Effort.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 6, 1949 *to* Sept 11, 1949 *that I last saw the deceased alive on* Sept 6, 1949 *and that death occurred at* 11:30 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
J. B. Stevens M. D.	3400 Edman Ave	9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/14/49	Baltimore National Cemetery	Frederick Rd. Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
SEP 13 1949	Certified from Baltimore, Md.	Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street

VS 150

94a

8081 — G78081

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MARY DORSCH

2. DATE OF DEATH: Sept. 12, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 534 N. Glover St.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 55 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 534 N. Glover St.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Feb 14, 1876
9. AGE (In years last birthday): 73 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hungary
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Hedwig Wagner, ADDRESS: 534 N. Glover St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(B) Arteriosclerosis generalized — 2 years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/26/ , 1948, *to* 9/12/ , 1949, *that I last saw the deceased alive on* 9/12/ , 1949, *and that death occurred at* 5:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Benj. B. Moore M. D.
23B. ADDRESS: 448 N. Luzerne Ave
23C. DATE SIGNED: 9/12/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/15/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State): 4430 Belair Rd. Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 1949
REGISTRAR'S SIGNATURE: Hunting for Williams M.D.
25. FUNERAL DIRECTOR. ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

83a

G78082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Vol. 1

G78082

Registered No.

ATH NO.

1. NAME OF DECEASED (Type or Print) Joseph Maranto

2. DATE OF DEATH September 12, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secour Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 285 S. Ellamont St 20-06

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 3/26/75
9. AGE (In years last birthday) 74 yrs
If Under 1 Year: Months 6 Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store keeper
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME — unk
14. MOTHER'S MAIDEN NAME Josephine VALENZIANO

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —

17. INFORMANT Leo MARANTO. ADDRESS St. B. Monastery St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pass. Coronary Thrombosis ? DUE TO — INTERVAL BETWEEN ONSET AND DEATH 4 hrs?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO —

(C) Senile prostatic Hypertrophy
Pneumonia (Malignancy?), right lung base.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 8/22/49, 19__, *to* 9/12, 1949, *that I last saw the deceased alive on* 9/12, 1949, *and that death occurred at* 2:25 *m., from the causes and on the date stated above.*

23A. SIGNATURE Frank A. Farano M. D.
23B. ADDRESS Dan Sisters Hosp
23C. DATE SIGNED 9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 9/15/49
24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.
24D. LOCATION (City, town, or county) 4300 Old Frederick Rd (State) Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR Thomas J Kenny Inc.
ADDRESS 1600 Hollins St

VS 150

137a

8083

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G78083

1. NAME OF DECEASED (Type or Print): Mary Ellen McElroy

2. DATE OF DEATH: 9-12-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1329 Crofton Road

c. Length of stay in Baltimore: 29 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1329 Crofton Road 27.09

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 6-29-1884
9. AGE (In years last birthday): 65
If Under 1 Year: Months: 2 Days: 14
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick O'Donnell
14. MOTHER'S MAIDEN NAME: Catherine McNally

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None

17. INFORMANT: Mr. James P. McElroy
ADDRESS: 1329 Crofton Rd.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Esophageal varices

DUE TO

(B) Diabetes

DUE TO

(C) Hypernephroma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* February, 1945 *to* Sept 12, 1949 *that I last saw the deceased alive on* Sept 10, 1949 *and that death occurred at* 4.40 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Jack J. Singer M. D.
23B. ADDRESS: 506 E North Ave
23C. DATE SIGNED: 9-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-15-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Belair Rd. Balto: Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 1949
REGISTRAR'S SIGNATURE: Hamilton Jon Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: George J. Ruth, Inc. 1735 Harford Ave. Balto: Md.

VS 150

52a

78084

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

60

G78084

Registered No.

1. NAME OF DECEASED (Type or Print): Loretta R. Mashof

2. DATE OF DEATH: 9/10/49

3. PLACE OF DEATH: a. Baltimore City, Maryland 1625 Belt St

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 1625 Belt B. COUNTY Balto Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) 1625 Belt St 24-04

5. SEX: F | 6. COLOR OR RACE: W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced | 8. DATE OF BIRTH: 12/31/1880 | 9. AGE (In years last Birthday): 68 69 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Wife | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Caleb Mashof

14. MOTHER'S MAIDEN NAME: Bridget Lasby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Linda Mc Hall ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Auricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (B) Myocarditis

DUE TO (C) Diabetes Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — | 19B. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Sept 3 49 to Sept 10 49, that I last saw the deceased alive on Sept 10 49, and that death occurred at 1:30 m., from the causes and on the date stated above.

23A. SIGNATURE: John C. Schemmel M. D. | 23B. ADDRESS: 1337 S. Charles St | 23C. DATE SIGNED: 9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 9/14/49 | 24C. NAME OF CEMETERY OR CREMATORY: Catherine | 24D. LOCATION (City, town, or County) (State): Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: J. J. Dabney & Son | ADDRESS: 318 Light St

VS 150

61

085 — BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G78085 — Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Walter Alton, Sr.

2. DATE OF DEATH: Sept. 13, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

Length of stay in Baltimore: 22 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eastport
D. STREET ADDRESS (If rural, give location): 1108 Court Drive

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 15, 1887
9. AGE (In years last birthday): 62
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheriff
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Alton

14. MOTHER'S MAIDEN NAME: Eliza Yates

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Union Memorial Hospital Records — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO

(B) Coronary thrombosis — 3 weeks

DUE TO

Arteriosclerotic heart disease

(C) Pulmonary edema, both lower lobes — days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 22, 1949 *to* September 13, 1949, *that I last saw the deceased alive on* Sept. 12, 1949, *and that death occurred at* 6:15 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: W. F. Coffey, M. D.
23B. ADDRESS: Union Memorial Hosp
23C. DATE SIGNED: 9/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): 9/15/49
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore MD.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John H. Taylor & Son
ADDRESS: Annapolis, MD.

VS 150

61298

937

G78086

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G78086

Registered No.

1. NAME OF DECEASED (Type or Print) Henry William Stuckey

2. DATE OF DEATH 9/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md 15-04
D. STREET ADDRESS (If rural, give location) 2116 N. Smallwood St

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single

8. DATE OF BIRTH Nov. 9, 1934

9. AGE (In years last birthday) 14

If Under 1 Year: Months Days

If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Carlton R. Stuckey

14. MOTHER'S MAIDEN NAME Bernice Veasel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mr. Carlton R. Stuckey ADDRESS 2116 N. Smallwood St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured Skull- Multiple Fractures

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Pennsylvania R-R 300 ft N. of Lafayette Ave

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 9/12/49 about 12½ P m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21F. HOW DID INJURY OCCUR? Struck by train

141

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE C. L. Leibrandt M.D.

23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED 9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9/15/49

24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.

24D. LOCATION (City, town, or county) (State) Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR WM. J. TICKNER & SONS

ADDRESS Balto., Md.

VS 151

169

G78087

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 8 19.0 G78087 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jessie Watson N-913-V

2. DATE OF DEATH Sept. II.1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkin hosp.

C. Length of stay in Baltimore 14 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.

D. STREET ADDRESS (If rural, give location) 883 Tyson St. 11-03

5. SEX Female

6. COLOR OR RACE Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH Dec.10.1902

9. AGE (In years last birthday) 46

If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY Private Family

11. BIRTHPLACE (State or foreign country) Blackstock S.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Spenu Dixon

14. MOTHER'S MAIDEN NAME Liza Pickett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Creola Roseborough 883 Tyson St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

DUE TO Laceration of Brain.

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Valley Rd., Route # 146, 6 miles north of the center of Towson--Balto.Co

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) September 10, 1949 6:15 a. m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Truck into bridge

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 9-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Sept. 15.1949

24C. NAME OF CEMETERY OR CREMATORY New Zion Cem.

24D. LOCATION (City, town, or county) (State) Blackstock S.C.

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR ADDRESS Elroy O. Wilson 1000 Brantly Ave

VS 151

170c

G78088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G78088 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Griffin Johnson

2. DATE OF DEATH Sept. 12.1949

3. PLACE OF DEATH: Baltimore City, Maryland Balto.Md.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 310 N. Calhoun St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 310 N. Calhoun St. 19-01

Length of stay in Baltimore 40 Yrs. (Yrs. Mos. Days)

5. SEX Male
6. COLOR OR RACE Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower
8. DATE OF BIRTH March 9.1893
9. AGE (In years last birthday) 56
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY Contractors
11. BIRTHPLACE (State or foreign country) Westmorland Co. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Richard Johnson
14. MOTHER'S MAIDEN NAME Emley Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Susetta Gaskin ADDRESS 310 N.Calhoun St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiovascular disease
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 year.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Aug 13, 1949 *to* Sept 12, 1949, *that I last saw the deceased alive on* Sept 12, 1949 *and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Wilmont L. Watts M. D.
23B. ADDRESS 515 Washington Blvd
23C. DATE SIGNED 9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept.15.49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 15 1949
REGISTRAR'S SIGNATURE Lexington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Elroy O. Wilson 1000 Brantly Ave.

VS 150

937

G78089

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G78089

1. NAME OF DECEASED (Type or Print): Lilly Broen Horsey Or Lillie Brown

2. DATE OF DEATH: (Sept. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (if rural, give location): 1429 E. Fairmont Ave. 5-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
F	C	S	Nov.5.08	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY: Private

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ervin Horsey

14. MOTHER'S MAIDEN NAME: Ellen Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Ellen Smith ADDRESS: 5 N. Spring St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary tuberculosis
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Sept. 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept.13.49	Mt Olivery Cem.	Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Elroy O. Wilson 1000 Brantly Ave

VS 151

130

G78090 ✓ 17° G78090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth Estelle LeCompte

2. DATE OF DEATH Sept. 11, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1204 Dukeland St.

Length of stay in Baltimore 64 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1204 Dukeland St., 16-07

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH June 2, 1885 | 9. AGE (In years last birthday) 64 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk

10B. KIND OF BUSINESS OR INDUSTRY Security Storage Co.

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George T. LeCompte

14. MOTHER'S MAIDEN NAME Elender L. Foos

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Miss Mary E. LeCompte ADDRESS 1204 Dukeland St.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Breast — INTERVAL BETWEEN ONSET AND DEATH 2½ yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION May 1947 | 19B. MAJOR FINDINGS OF OPERATION Carcinoma of Breast | 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 2- 1949 to Sept 11 1949 that I last saw the deceased alive on Sept 11 1949, and that death occurred at 6:05 P m., from the causes and on the date stated above.

23A. SIGNATURE M. D. M. J. Mendenhall | 23B. ADDRESS 1136 Poplar Grove St | 23C. DATE SIGNED 9/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-14-1949 | 24C. NAME OF CEMETERY OR CREMATORY Baltimore | 24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR G. Howard Strong | ADDRESS 3207 W. North Ave.,

VS 150

290 52 50

78091
RTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G78091

1. NAME OF DECEASED (Type or Print) BABY MCCANN

2. DATE OF DEATH Sept. 11, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fork
D. STREET ADDRESS (If rural, give location)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	white	S.	Sept 10-49				8	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Geo. B. McCann

14. MOTHER'S MAIDEN NAME Dorcas Caton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Edw McCann ADDRESS Kingsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

II
(C)
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE C. F. Leibrecht M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR
23C. DATE SIGNED Sept. 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 13-49	Fork M. E. Cem	Fork Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR C. E. Arthur ADDRESS Fork Md.

VS 151

161a

78092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G78092

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice L Lowe

2. DATE OF DEATH: Sept 13, 1949

3. PLACE OF DEATH: Baltimore City, Maryland — 6 W. Fort Ave

FULL NAME OF HOSPITAL OR INSTITUTION: 6 W. Fort Ave (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN: Balto (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 6 W. Fort Ave 23-01

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 16, 1869
9. AGE (In years last birthday): 80
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Cole
14. MOTHER'S MAIDEN NAME: Mary Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Alice L Smith — ADDRESS: 4118 Shubert Ave

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia (hypostatic) — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

(B) Chronic asthmatic bronchitis, Emphysema

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic myocarditis — 2

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from 9/4, 1949, to 9/13, 1949 that I last saw the deceased alive on 9/12, 1949 and that death occurred at 1230 a m., from the causes and on the date stated above.

23A. SIGNATURE: Harry Deibel, M. D.
23B. ADDRESS: 122 Hanover St.
23C. DATE SIGNED: 9/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 15, 1949
24C. NAME OF CEMETERY OR CREMATORY: Loudon Pk
24D. LOCATION (City, town, or county) (State): Balto

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. Edward Evans
ADDRESS: 1400 St Paul St

VS 150

937

78093

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G78093

BTH NO.

NAME OF DECEASED (Type or Print) Daniel J. Brown

2. DATE OF DEATH Sept. 11, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1015 Harlem Ave.

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1128 N. Stricker St.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Male	Colored	Married	Mar. 21, 1885	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME William Brown

14. MOTHER'S MAIDEN NAME Bettie Pope

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Annie Brown ADDRESS 1128 N. Stricker St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pulmonary edema

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 31, 1949 *to* Sept. 11, 1949, *that I last saw the deceased alive on* Sept 8, 1949, *and that death occurred at* 11:25 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Jos Ridenour M. D.

23B. ADDRESS 612 Edmondson Ave.

23C. DATE SIGNED 9-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9-14-49

24C. NAME OF CEMETERY OR CREMATORY Mt. Calvery Cem.

24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Mrs. Frances A. Hemsley ADDRESS 578 W. Biddle St.

VS 150

111B

78094 G78094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

RTH NO.

NAME OF DECEASED (Type or Print) Anna O. Chase

2. DATE OF DEATH September 12, '49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1508 N. Pulaski St.

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Marylnd
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1508 N. Pulaski St. 15-03

SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
emale	Colored	Widow	Oct. 11, 1881	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Marylnd

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Winslow Oliver

14. MOTHER'S MAIDEN NAME Hester Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 18 months
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Rheumatoid Arthritis

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 30 1947 *to* Sept. 12, 1949 *that I last saw the deceased alive on* Sept. 12, 1949 *and that death occurred at* 10 *m., from the causes and on the date stated above.*

23A. SIGNATURE Ralph W. Pollitz M. D. | 23B. ADDRESS 4 E. N. Johns Pl | 23C. DATE SIGNED 9/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9-15-49	Arbutus Mem. Cem.	Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 13 1949

REGISTRAR'S SIGNATURE Beatrice for Williams, M.D.

25. FUNERAL DIRECTOR Mrs. Frances A. Hemsley ADDRESS 578 W. Biddle St.

VS 150

8313

78095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G78095

IRTH NO.

1. NAME OF DECEASED (Type or Print): Charles E. Collins

2. DATE OF DEATH: Sept 10 - 1949

3. PLACE OF DEATH: Baltimore City, Maryland — Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE
b. COUNTY
1357 N. Carey St Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-01
d. STREET ADDRESS (If rural, give location): 1357 N. Carey St.

e. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

f. Length of stay in Baltimore: 3 Yrs. Mos. Days

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 24 yrs
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: SUGAR REFINING
11. BIRTHPLACE (State or foreign country): Louisiana
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Edna —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
16. SOCIAL SECURITY NO. (If yes, give war or dates of service): 431-36-30[illegible]
17. INFORMANT: Ernestine Collins ADDRESS: 1351 N. Carey

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Stab Wound of Heart
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Northwest corner of Laurens & Carey Sts.
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Sept. 10, 1949 1.30pm
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCoccur? Sharp instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L. Koon M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 11 Sept 49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: New Orleans Louisiana
24D. LOCATION (City, town, or county) (State): Louisiana

DATE RECEIVED BY LOCAL REGISTRAR: SEP 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Wm Brooks Pugg
ADDRESS: 1463 N. Carey St

98 x 6

167

096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49 96

G78096

Registered No.

BIRTH NO. BC 49-1474

1. NAME OF DECEASED (Type or Print): Claude Clarence Woodson III

2. DATE OF DEATH: 7/24/49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

Length of stay in Baltimore: ~~Yrs.~~ ~~Mos.~~ 6 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1610 W Lanvale St

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 7/18/49
9. AGE (In years last birthday): If Under 1 Year: Months: — Days: 6 If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Claude Clarence Woodson Jr
14. MOTHER'S MAIDEN NAME: Ruth Alma Bivens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Ruth Woodson
ADDRESS

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity. 2' 8½"
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 18, 1949, *to* July 24, 1949, *that I last saw the deceased alive on* July 24, 1949, *and that death occurred at* 6:05 *m., from the causes and on the date stated above.*

23A. SIGNATURE: M B Butler M. D.
23B. ADDRESS: Provident Hospital
23C. DATE SIGNED: 8-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): SEP 13 1949

DATE RECEIVED BY LOCAL REGISTRAR: SEP 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D. Commissioner of Health
25. FUNERAL DIRECTOR
ADDRESS

VS 150

159

8097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

RTH NO. G78097 Registered No.

NAME OF DECEASED (Type or Print) Robert M. Downey

2. DATE OF DEATH 9-12-49

PLACE OF DEATH: Baltimore City, Maryland Balto. Md.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 222 E Churchill St 27-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Male	White	Married

8. DATE OF BIRTH 4/30/1886 | 9. AGE (In years) last birthday) 63 yrs | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Robert M. Downey

14. MOTHER'S MAIDEN NAME Mary Dowling.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Ida May Downey ADDRESS 222 E. Churchill St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral pneumothorax — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Ruptured emphysematous bleb

DUE TO

(C) Pulmonary emphysema, severe

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about house, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/12/49, 19__, to 9/12/49, 19__, that I last saw the deceased alive on 9/12/49, 19__, and that death occurred at 9 P m., from the causes and on the date stated above.

23A. SIGNATURE Ralph D. Grayson M. D. | 23B. ADDRESS 1213 Light St. | 23C. DATE SIGNED 9/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | 24D. LOCATION (City, town, or county) (State) Ritchie Highway

DATE RECEIVED BY LOCAL REGISTRAR SEP 14 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR John F. Denny, Inc ADDRESS 715 Light St -30

VS 150

113

3098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1949-1 078098

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BERTHA HOCKMAN

2. DATE OF DEATH 9-13-49

3. PLACE OF DEATH: Baltimore City, Maryland 3706 Hortonia Rd (If not in hospital or institution, give street address or location)

FULL NAME OF HOSPITAL OR INSTITUTION The Mount

Length of stay in Baltimore 43 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2907 Oakley Ave

5. SEX female

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH

9. AGE (In years last birthday) 75

If Under 1 Year: Months Days

If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Moses Pecker

14. MOTHER'S MAIDEN NAME Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Charles Lockman ADDRESS 2884 W Lafayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of head — INTERVAL BETWEEN ONSET AND DEATH 5 m.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocardial infarct (Acute)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION April 15-49

19B. MAJOR FINDINGS OF OPERATION Malignancy

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/11 1949 *to* 9/13 1949, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 5H m., *from the causes and on the date stated above.*

23A. SIGNATURE W J Bayliss M. D.

23B. ADDRESS 2040 Eutaw Pl

23C. DATE SIGNED 9/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9-14-49

24C. NAME OF CEMETERY OR CREMATORY Bnai Israel

24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 14 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

VS 150

53

8099 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

970 ✓ G78099 Registered No.

1. NAME OF DECEASED (Type or Print) JACOB J. BELEMER — N-971-0

2. DATE OF DEATH: September 12, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Marlborought Apartments

Length of stay in Baltimore: 27 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-01
D. STREET ADDRESS (If rural, give location): Marlborough Apartments, Wilson & Eutaw Pl

5. SEX: male
6. COLOR OR RACE: ~~white~~ White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH:
9. AGE (In years last birthday): 64 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not known
14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Paul Schratter — ADDRESS: 1104 Norwood Ave

CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Barbiturate poisoning
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Coronary artery disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [x] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [x] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Marlboro Apartments Eutaw Pl & Wilson St
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): September 12, 1949 ? m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [x]
21F. HOW DID INJURY OCCUR? Ingestion of barbituric acid derivitive

22. *I certify that I took charge of the remains described above, held an* autopsy (mp) *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [x], homicide [ ], undetermined [ ].*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [x] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 9-14-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 14 1949
REGISTRAR'S SIGNATURE: [signature] M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

MEDICAL CERTIFICATION

VS 151

163 B

78100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53 G78100

Registered No.

RTH NO.

1. NAME OF DECEASED (Type or Print) Theresa Schneider

2. DATE OF DEATH Sept 10-1949

PLACE OF DEATH: Baltimore City, Maryland 1814 McHenry St

FULL NAME OF HOSPITAL OR STITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1814 McHenry St

Length of stay in Baltimore 67 yrs Yrs. Mos. Days

19-04

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	White	married	7	67		

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME ? Moseman

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT Harry Schneider ADDRESS 1814 McHenry St

CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Bronchopneumonia Bilat. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Carcinoma (adenoca) of Sigmoid c ⟷ 6-12 mo

DUE TO metastases to liver.

(C) Arteriosclerosis generalized.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 10th, 1949, to Sept 10th, 1949, *that I last saw the deceased alive on* Sept 10th, 1949, *and that death occurred at* 10:05 P m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
R. Lamb M.D. M. D.	642 North Ave	9-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Sept 14-1949	Glen Haven Memorial	Anundel Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
SEP 14 1949	Huntington Williams, M.D.	Joseph Kasmeksa Jr	602 Wash.

VS 150

46E

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

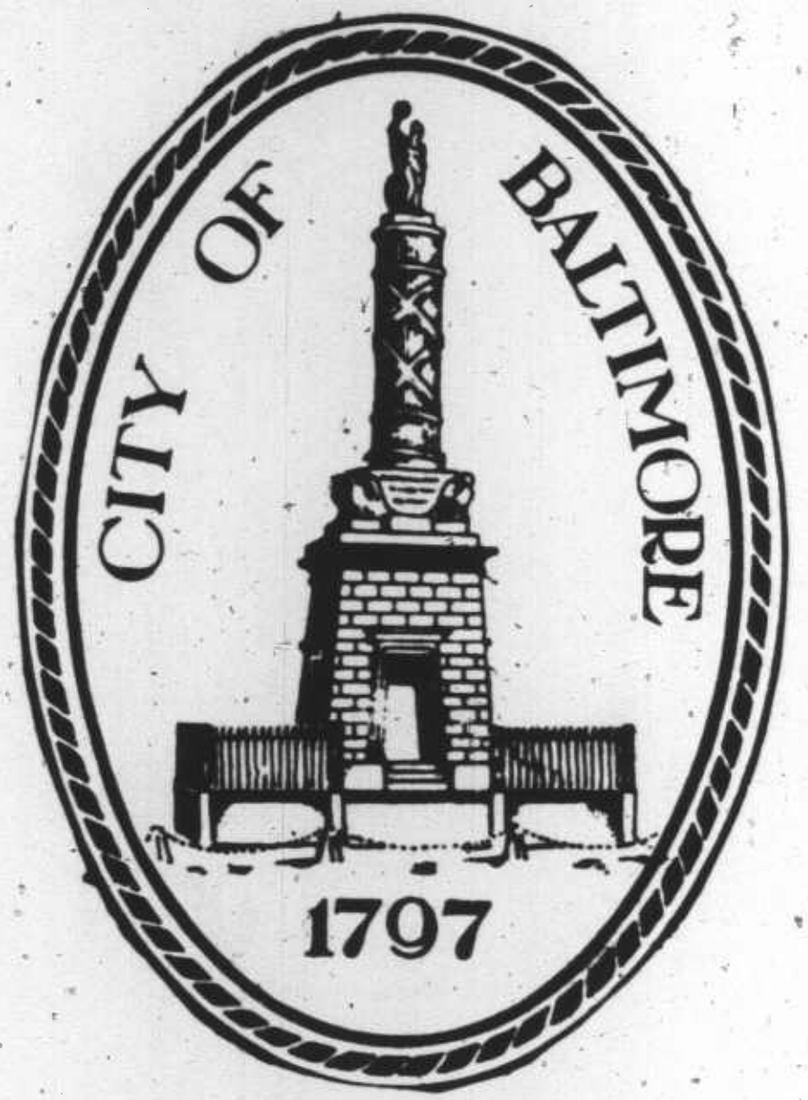
RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 9-16 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 75211, AND ENDING WITH 78100 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health- BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne
Asst. Supv.



END OF REEL